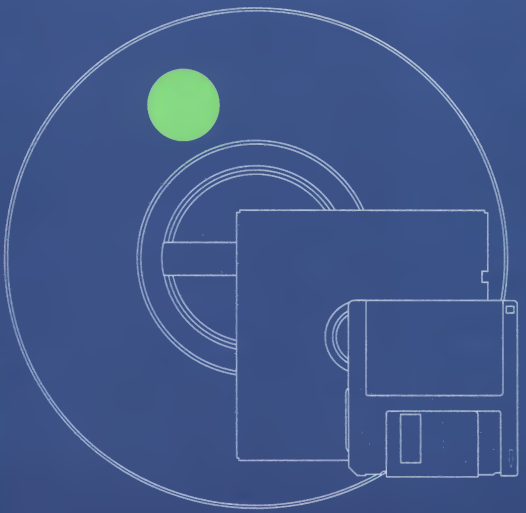
Medicare Statistical Files Manual



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MEDICARE STATISTICAL FILES MANUAL

This manual is prepared by the Office of Statistics and Data Management (OSDM), Bureau of Data Management and Strategy (BDMS), Health Care Finncing administration (HCFA). The purpose of the manual is to provide information about the various statistical files available within HCFA concerning the Medicare program. It is intended to provide enough detail about each file so that persons interested in the Medicare program can determine what data are available. It is not designed for use by computer personnel to write programs or perform detailed systems design.

Most files are annual files subject to limitations such as currency, changes in coding structure, changes in volume, changes in sample size, availability of information, legislative changes and others. The reader should bear in mind that not all files for a given reference period may be available for processing or resources may not be available to process them. This July 1988 issuance contains either revisions or additions to the April 1987 issuance.

THE INFORMTION IN THESE FILES IS CONFIDENTIAL AND USED FOR ADMINISTRATIVE AND STATISTICAL PURPOSES ONLY. THE RELEASE OF ANY INFORMATION IS SUBJECT TO THE PRIVACY ACT AND OTHER FEDERAL GOVERNMENT RULES AND REGULATIONS.

Further information on the Medicare Statistical Files and data produced can be obtained by contacting the Chief, Data Quality and Documentation Branch, OSDM, BDMS, HCFA, Room 1-F-2 Oak Meadows Building, 6325 Security Blvd., Baltimore Maryland 21207 by mail or by telephone at the following numbers: FTS 646-5304 or (301) 966-5304.

Frank Kirby

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Fiscal Intermediaries

Under the HI program, fiscal intermediaries (FI's) are selected by each institutional provider (hospitals, skilled nursing facilities, home health agencies) to act as the link between the provider and the Health Care Financing Administration. A vital role of the intermediaries is to review and pay claims for the cost of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services and assists in the application of safeguards against unnecessary use of covered services.

For institutional providers not on prospective payment, the reimbursement amount shown on the billing records is an interim payment based on estimates of actual costs. Each institution is required to prepare a cost report at the end of its fiscal year and final reimbursement is made on the basis of this report. These cost reports are professionally reviewed and audited as necessary by the FI. Portions of the cost reports are transmitted to HCFA to be used in rate setting and policy development.

For hospitals on prospective payment, the diagnostic, surgical, and other pertinent information shown on the billing forms are edited and then processed through a computer program called GROUPER to assign the DRG. If there are problems with the codes, the FI resolves them with the hospital. Once the DRG is assigned, the bill is processed through other operations to determine the price Medicare will pay. Hospitals on prospective payment are also required to file cost reports.

Carriers

Under the SMI program, carriers are selected by the Secretary of Health and Human Services. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or on behalf of beneficiaries for the services provided. They also maintain customary and prevailing charge profiles of physicians in their geographic area.

Social Security Administration

The Social Security Administration (SSA) maintains demographic and entitlement information on all OASI, Disabled, and ESRD beneficiaries. The Health Insurance Master (HIM) file is updated daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and terminations, cross-reference of claim numbers, changes of address, and other changes which are received from the SSA and the Railroad Retirement Board master beneficiary record (MBR) systems. Utilization data consist of: notices of hospital admissions, SNF admissions, Part B deductible queries, provider billing records from intermediaries, and payment records from carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative processes.

Hospital Insurance Claims Process

The HCFA Central Office HI Claims process operation is essential to provide current benefit and utilization information to intermediaries. It also monitors intermediary payment to institutional providers. When a beneficiary is discharged, the participating

provider submits a bill to the intermediary. The intermediary then transmits the information as a query to HCFA to check the beneficiary's status and validate entitlement, deductible, and coinsurance information on the bill. Based on the information furnished by HCFA, the intermediary certifies payment to the provider. The intermediary then forwards the bill record to HCFA for processing through HCFA's administrative operations. This billing record is also sent to the local Peer Review Organization (PRO) for quality review.

Consistency Editing

This operation (performed centrally in HCFA) balances the number of bills and reimbursement amounts to the intermediary's total to establish acceptable tape totals for use through the remainder of the automated processing. A computer edit program identifies all invalid data and inconsistencies for each bill. Invalid data include such items as a month indicated by a number greater than 12, more than 60 lifetime reserve days used, and so forth. The DRG on prospective payment hospital bills is also edited.

The consistency edits do not compare data on the bills to information in HCFA records. These edits are used as a screen to check the consistency of data on the bill itself.

Utilization Editing

Once the consistency edits have been applied, the bills go through the utilization editing program. In this program, the bill data on the tape are compared to the data in HCFA's Health Insurance Master Record.

The bills in the batch which failed the consistency edits are screened in the utilization program for only three items:

1. name and claim number which match the master record,
2. eligibility to Part A or Part B benefits during the billing period, and
3. a matching open item on HCFA's Health Insurance Master Record. "Open" items are created from admission notices and are "Closed" by discharge bills or deletion queries.

Bills which have passed the consistency edits are processed completely through the utilization editing program and are either posted or rejected. The detailed edits resulting in a potential 300 distinct error conditions are described in Section 3830 of the Part A Intermediary Manual. This manual is maintained by the Bureau of Program Operations, HCFA.

Rejected bills are returned to intermediaries for correction and reinstatement (or voiding). Both bills and batches are held in the control system until their processing is completed or until they are deleted. Reports of batch processing, batch completion, and outstanding returned bills are periodically sent to intermediaries to use in reconciling batches submitted and in checking on bills to be corrected and returned to HCFA. Records of the bills passing initial edits are passed on to the Beneficiary Master Update operation; which records the transactions on the individual's HI Master record, and generates records for updating the provider Master File; and to a history record of completed billing transactions. The update operation will also generate a beneficiary utilization notice where an interim or a final (discharge) bill is processed for inpatient services or home health visits.

Part A inpatient bill information is processed on an "in sequence" basis. This sequence is determined from the billing dates "from" and "to" present on each bill. Bills are processed in "from" date sequence within a benefit period.

Medical Insurance Claims Process

Part B outpatient bills and Part B home health agency bills are submitted from intermediaries, while Payment Records covering physician, supplier, and ambulatory surgical center services are submitted from carriers. The processing procedure differs from that for Part A bill records because, unlike Part A, Part B benefits are not tied to a benefit period with a limited number of days of care and varying coinsurance amounts. Under Part B, only physical therapy and psychiatric services have an annual limitation on benefits payable.

Claims for payment of Part B benefits are submitted to the carrier or intermediary by beneficiaries or the supplier of services (such as physicians). When the carrier or intermediary queries HCFA on the beneficiary's deductible status, the utilization query/reply operation handles the transaction similarly to Part A queries.

In addition, Part B queries update the Part B deductible and record physical therapy and psychiatric expenses. The carrier or intermediary determines and makes payment to the claimant, taking into account the beneficiary's deductible status.

Carriers submit Payment Records for all physician and supplier claims for which payment is made. These Payment Records are batched and transmitted to HCFA where they are edited and then matched against the HI Master Record to check for beneficiary entitlement and, if appropriate, to record physical therapy or psychiatric services. A listing of rejected records is returned to carriers for corrections and the records are held in a suspended record file. As records are corrected and returned, they are deleted from this file. In addition, another operation controls the batches of Payment Records and provides statistical reports on bill processing by each carrier.

The Explanation of Medicare Benefits (EOMB) is an important function of the carriers and is used to notify each claimant for Part B benefits of the action taken on his claim. Section 7000 of the Medicare Carrier's Manual provides an in-depth description of the purpose and contents of the EOMB. This manual is maintained by the Bureau of Program Operations, HCFA.

Carriers send HCFA monthly reports of amounts paid during the month for SMI services. Batches of Payment Records are matched against these carrier financial reports to determine if submitted records of payments by carriers balance HCFA's reimbursement to them for Part B payment made. HCFA then reconciles any differences.

HCFA does not receive bills for Part B services rendered by certain Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's). These groups deal directly with HCFA and are reimbursed on a per capita cost basis.

Provider Of Service Master File

Institutional providers of services (hospitals, SNF's, and HHA's) participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing care for the beneficiaries of the

two programs. The certification is done by State agencies according to HCFA guidelines and regulations. The qualifications are reviewed periodically, following the same procedure.

The State agency surveyor applies various criteria to measure an institution's capability of providing acceptable care. At the same time, provider characteristics such as staffing, number of beds, and services provided are recorded on a forms package. This forms package is divided into two sets. The first set, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the institution being evaluated. For example, the surveyor evaluates such areas as staffing, physical environment, medical records, nursing, and dietary departments in hospitals and nursing homes. The second set comprises the source documents for the Provider of Service (POS) master file, and includes the Certification and Transmittal Form (C&T) and the application form. The C&T Form records address information, intermediary tie-in, and the certification decisions and certification approval dates of the State agency and the HCFA regional office. The application form contains the provider characteristics (type, control, staff, services, etc.).

When the on-site survey by the State agency surveyor has been completed, it is reviewed and approved by the State agency and forwarded to the HCFA regional office for review and final certification by the regional office. The reviewer ascertains that all forms are present and properly prepared. The data items that are prescribed for entry into the data base are then keyed to magnetic disk. The first group of consistency checks are applied as the data are entered. Incorrect entries alert the operator via a Cathode Ray Tube (CRT) display screen and for certain fields prevent further entry of the forms package in question until corrections are made. Those forms packages successfully keyed to the disk are batched daily in the regional office and transmitted via telephone lines to central office. A transaction record is built in central office by combining all the POS and SRF data elements into a single record for each provider of service. This record is next passed through a more extensive series of consistency checks for accuracy and completeness. The fully edited record is then entered into the provider of service master file.

The Medicare Decision Support System

The primary objective of the Medicare Statistical System (MSS) is to provide data required to measure and evaluate the operation and effectiveness of the Medicare program and to provide data for pre-decision support. The benefit payment operations furnish the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by Medicare beneficiaries, as well as the costs of such services. The applications submitted by hospitals, skilled nursing facilities, and home health agencies to participate in the Medicare program provide data on the characteristics of such providers of services. The claim number that is assigned to each beneficiary serves as the link between the various services used under the program and the demographic characteristics of each individual recorded in the enrollment files.

The data-collection system has two inherent characteristics that greatly determine the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, and costs, all program statistics are centrally prepared.

The statistical system is based on six basic record groups which are byproducts of the Health Insurance Administrative operations. The record groups are described below.

- The Health Insurance Master Enrollment Record - This record identifies each person (aged and disabled) enrolled for Medicare. Data describing the characteristics of the Medicare enrolled population are obtained from this file. This file also serves as the basis for obtaining Medicare utilization rates. Approximately 28 million aged beneficiaries and 3 million disabled beneficiaries are currently entitled to Medicare benefits.

- The Provider of Service Record - This file contains information on every hospital, skilled nursing facility, home health agency, independent laboratory, and other institutional provider which must apply for participation in the program. Each is assigned a distinct provider number. Approximately 6,700 hospitals, 6,100 SNFs, 5,200 HHAs, 3,900 independent laboratories, and 1,600 other types of facilities that participate in Medicare are on this file.

- The Utilization Record - Part A and Part B billing information is maintained centrally; and these records are tabulated monthly, quarterly, and annually to measure the use of Medicare services. While the annual volume of Medicare bills processed will vary from year to year, the approximate number processed in any year is as follows:

Inpatient hospital	11,000,000
SNF	800,000
Outpatient	42,000,000
HHA (A and B)	5,000,000
Payment Records (physicians and suppliers)	360,000,000

- The Provider Cost Report Record - This record includes provider fiscal periods which are necessary to rate setting and to policy development. Cost data are captured on institutional providers; i.e., hospitals, SNF's, HHA's, and ESRD facilities.

- The Special Program Data - Data are collected specific to special programs within Medicare; e.g., ESRD and, as necessary, for the purpose of research, demonstrations, and policy analyses; e.g., SSI days for disproportionate share hospitals.

- The Part B Medicare Annual Data Files (BMAD) - These are supplemental Part B data files developed from carrier supplied claims history records. The files and approximate number of records contained in each are as follows:

Procedure File	7,000,000
Prevailing Charge File	1,500,000
Provider File	3,000,000
Beneficiary File	1,700,000

Since each utilization record contains both the beneficiary's claim number and the provider's Medicare identification number, these records can be matched to the Enrollment and Provider records. By this process we create statistical records that contain the information needed for tabulations from the three files.

The billing information reported includes days of care, detailed ancillary charges, Medicare reimbursement amounts, discharge status, diagnostic and surgical information. By mid-1985, all institutional providers were reporting on the HCFA 1450 (uniform bill) billing form.

Prior to October 1983, the diagnostic and surgical information was reported in narrative form (up to 45 characters for diagnosis and 41 characters for surgery) for samples of bills only. Only one diagnosis and surgical procedure (if any) was coded. The coding system in use since 1979 is ICD-9-CM Volumes I and II for diagnosis and ICD-9-CM, Volume III, for surgical procedures. For services before 1971, ICDA-7 was used; and from 1971 - 1978, it was ICDA-8.

In October 1983, hospitals were required to report only ICD-9-CM codes for inpatient hospital bills. Narratives were no longer permitted. Inpatient hospital bills were to contain codes for the principal diagnosis and up to four additional diagnoses and principal surgical procedure and up to two additional surgical procedures, if any. Inpatient hospital bills also were required to contain a Diagnosis Related Group (DRG) number to determine reimbursement for prospective payment. The DRG is assigned by the fiscal intermediary by processing the billing information through a computer program called GROUPER.

Medicare bills other than inpatient hospital, outpatient, home health, and skilled nursing facility were still reporting either narratives or codes until April 1985 when only ICD-9-CM codes were permitted.

Effective July 1986 providers were required to report clinical laboratory procedures using HCPCS codes. HCFA developed HCPCS by using CPT-4 for physician services and adding HCFA developed codes for certain nonphysician services. All of CPT-4 is contained within HCPCS. In July 1987, providers were required to report significant outpatient surgical procedures using HCPCS.

MAJOR MEDICARE STATISTICAL FILES BY DATA CATEGORY

Most Medicare statistical files are summarized on a calendar-year basis by the year the service was incurred. The files contain varying amounts of detail on charges, days of care, Medicare reimbursement, beneficiary characteristics, and provider characteristics. In addition to the files, an ongoing series of detailed tabulations are

prepared containing data on enrollment, bills, charges, days of care, and reimbursements by type of Medicare benefit Nationally, by State, and some, even by county of residence.

A. Utilization - Institutional Providers

1. Medicare Provider Analysis and Review (MEDPAR)

   An annual file of hospital discharges containing detailed accommodation and departmental charge data, days of care, diagnostic/surgical information, and beneficiary demographics. The file size was increased to 100 percent on October 1, 1983. Previously, MEDPAR was for a 20 percent sample of beneficiaries.

2. Provider Summary Record - 100 Percent

   This file contains current and prior-year summary utilization information by Medicare certified hospital, including number of bills, days of care, charges, and reimbursement. This file is primarily used for Admission Pattern monitoring and Prospective Payment System monitoring.

3. Annual Home Health Agency Bill File - 40 Percent Sample

   Contains HHA billing data and beneficiary characteristics.

4. Annual Outpatient Bill File - 5 Percent Sample

   Contains outpatient billing information and beneficiary characteristics.

5. Skilled Nursing Facility Stay Record File - 100 Percent

   An annual file of admissions with billing information, admitting diagnosis, and beneficiary characteristics.

B. Part B Data - Physicians Ambulatory Surgical Centers and Suppliers

Part B Medicare Annual Data Files (BMAD)

The Part B data are provided in four separate files; carriers extract the data annually from their claims processing history files.

1. Procedure File - Provides an array of every procedure processed showing the related frequency, submitted charge, and paid amount. This gives HCFA detail on the services processed by carriers.

2. Prevailing Charge File - Provides HCFA with the prevailing charge limits for each service contained in the Procedure File. This allows HCFA to study and accurately project payment levels. It is currently being used to establish clinical lab fee payment schedules.

3. Provider File - Contains line-by-line detail from claims history of procedures rendered by a 1 percent sample of physician/suppliers. This allows HCFA to study the impact of actual and projected program changes on them. It also allows HCFA to conduct longitudinal analysis of practice trends. This sample is increased to 5 percent for 1985.

4. Beneficiary File - Contains line-by-line detail from claims history of services received for a 5 percent sample of aged and disabled beneficiaries and all ESRD beneficiaries. This allows HCFA to link, based upon the beneficiary health insurance claim number, a beneficiary's Part B service utilization data with the Part A service utilization data that exists in other CO files.

C. Longitudinal Utilization and Beneficiary Data

1. Continuous Medicare History Sample - 5 Percent Sample

A summary file which links data covering all Medicare benefits on a 5 percent sample of beneficiaries' characteristics on a continuous annual basis. Beneficiary characteristics and data on each hospital and SNF stay along with diagnostic and surgical information is included. The file can be used as a longitudinal statistical data base to study beneficiary utilization of all Medicare benefits.

2. Medicare Automated Data Retrieval System (MADRS)

MADRS is designed to reorganize the massive 100 percent Bill and Payment Record File to index them so that it will be easier and less expensive to retrieve data for research and demonstration purposes.

MADRS contains 100 percent of hospital bills, outpatient bills, skilled nursing facility bills, home health bills, and physician and supplier payment records. For office visits, only summarized payment record data are available. The more important data elements available in these claims are patient health insurance number, provider number, HMO enrollment, reason for entitlement, dates of service, types of services, diagnosis, charges, reimbursed amounts, and coinsurance and deductibles.

MADRS is accessible by either health insurance claim number or state and county of residence.

D. Financial Data

1. Hospital Cost Report Information System (HCRIS)

HCRIS is an automated data collection, processing, and report generation system that contains hospital-specific financial and statistical cost report data from Medicare certified hospitals and hospital/health care facility complexes beginning with hospital fiscal years ending on or after January 1, 1982. HCRIS also contains Title V and/or Title XIX data when

the hospital is reimbursed under the program(s) on a reasonable-cost basis and the Medicare Fiscal Intermediaries (FI's) are responsible for processing and setting their cost reports.

2. Section 223 Cost Limit File for SNF's and HHA's

This file contains data abstracted from cost reports submitted by SNF's and HHA's. The file is processed to develop the limits on Medicare payments to these institutions, as mandated by Congress.

E. Institutional Provider Identification and Certification

1. Provider of Services

As a by-product of the Medicare/Medicaid Provider certification process (MMACS), data which identifies and characterizes the participating institutional providers (hospitals, HHA's, etc.) are collected through the States and regions and recorded centrally in a continually updated data base. The data are used both administratively by HCFA and/or the PRO's and for many statistical reports. Additionally, the POS data are appended to the billing records to enable tabulation of utilization by provider characteristics, as necessary.

2. Provider Specific File

The Provider Specific File is a component of the PRICER program used in the FIs' systems to compute individual DRG payments. It is needed in central office to supply essential data elements in the PPS recalibration processes and related PPS activities. The FI's have been instructed in a manual issuance to submit the history of Provider Specific records at the end of each calendar quarter.

F. Beneficiary Entitlement and Demographics

Health Insurance Skeleton Write off (HISKEW) - 100 Percent

This file contains selected beneficiary entitlement and demographic information from the Health Insurance Master File such as age, sex, race, State, County, ZIP-Code, and entitlement. It is used to prepare an ongoing series of enrollment tabulations detailing the number and characteristics of Medicare beneficiaries, e.g., 1984 enrollment is prepared from the March 1985 HISKEW.

G. ESRD Program Data

End-Stage Renal Disease Program Management And Medical Information System (ESRD PMMIS)

The ESRD PMMIS is a uniform data base of national scope which contains basic medical and program management data elements related to the services provided by Medicare-approved ESRD facilities in the treatment of dialysis and kidney transplant patients:

The ESRD PMMIS is a comprehensive patient-based system which includes, by patient:

1. identifying characteristics,
2. primary disease,
3. first date of ESRD care,
4. incidence records on dialysis and transplantation,
5. incidence of hospitalization and outpatient care, and
6. date and cause of death,

and an all inclusive facility-based system which includes, by Medicare-approved ESRD provider:

1. identification and certification characteristics, and
2. aggregate treatment surveys.

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Further information on the Medicare Statistical Files and data produced can be obtained by contacting the Director, Division of Data Development, OSDM, BDMS, HCFA, Room 1-F-2 Oak Meadows Building, Baltimore, Maryland 21207.

III. Provider of Services Master File

Introduction

Institutional providers of service (hospitals, Long Term Care (LTC), Home Health Agency (HHA), etc. participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing safe and effective care for the beneficiaries of the two programs. The certification procedure is conducted, under federal guidelines, by an agency of the state where the institution is located. Final approval comes from the Health Care Financing Administration. After the initial certification, the qualifications of an institution are reviewed periodically, culminating in a decision to retain or terminate participation.

Source Documents and Input

The observations and decisions of the State agency surveyors, when applying the various criteria which measure an institution's capability of providing acceptable care as well as characteristics such as staffing, bed size, and services, are recorded in a forms package. This package is divided into two sets: the first, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the particular institution. The second set comprises the source documents for the Provider of Services (POS) Master File and includes the certification and transmittal (Exhibit A) and the application (Exhibit B). A separate version of the application form is used for each type of provider (hospital, LTC, HHA, etc.).

The complete forms package (POS and SRF) is converted on a flow basis on line to the central office update systems over wire transmission lines from the HCFA regional office (RO) or the State agency where the files of the original source documents are maintained.

Update Mechanism and Quality Control Measures

The update cycle for the POS/SRF system is daily. The data entry and point-of-entry consistency checking, however, are on-line. The data elements are keyed by the regional office or State agency using terminals linked by wire to the HCFA Data Center. Data elements not passing consistency checks are earmarked for subsequent corrections by the RO. Nightly, the data elements are sorted and assembled for each provider into a transaction record. Transactions without point-of-entry errors are matched/merged to the MMACS master file. In the matching process the transaction records undergo a second tier of consistency checks (comparison edits, e.g., inordinate increases/decreases in bed size or staffing). Only error-free transactions are updated to the master file; those with errors are held on a pending transaction file awaiting resolution by the RO.

Transactions that successfully entered the master file and rejected transactions are disposed of as follows: accretions without error are added to the data base; recertifications replace the associated earlier certifications, which are placed on a separate history file; corrections and termination actions overlay or add the prescribed data elements to the existing record. All new transactions, including those that failed to pass the consistency check, those that failed to match the master data base, and those that were successfully applied to the master data base, are transmitted over the telecommunication network to the regional office. The entire process is set to a daily

schedule so that the regions receive the disposition of the records they originally transmitted the morning following their transmission to central office.

In addition to the computer consistency checks, OSDM periodically performs a manual check of selected fields of transactions applied to the POS portion of the master data base. Periodic notes are sent to HSQB showing erroneous transactions which are not amenable to automated edits but are uncovered through comparison to other data sources.

Exhibits C and D detail the record contents of the POS portion for hospitals and LTC's respectively. Record contents for the HHA portion are shown in Exhibit E. During this phase of the update system, a segment indicating errors discovered is appended to the transaction record.

Dependent Systems and Outputs

The POS file is used to support a number of Health Insurance administrative data processing systems. These include the following:

1. RADARS

   RADARS is a rapid data retrieval system that is available to the regional offices and interested central office components that permit lay users to extract current unit record listings and aggregated data through control statements entered via a terminal. Both SRF and POS data are available for extraction.

2. Provider Cost Report Monitoring System

   The POS file serves as a control file for this system for SNF and HHA cost reports which monitors the progress of cost reports through the various stages of audit and settlement.

3. Provider Specific File

   The Provider Specific File is developed by the intermediaries for use in the hospital prospective payment system pricing mechanism. A reimbursement price is computed for an individual inpatient hospital stay depending on the Diagnostic Related Group (DRG) the stay is classified in. The Provider Specific File is used in central office to support DRG recalibration; its completeness is measured by comparison to the POS file.

4. Federal Monitoring Surveys

   This effort by HCFA monitors the State agency performance in surveying health care facilities for Medicare/Medicaid certification. The POS/SRF information is used to support this activity, and the documentation of the monitoring is captured in the MMACS.

5. Chain Ownership Tracking

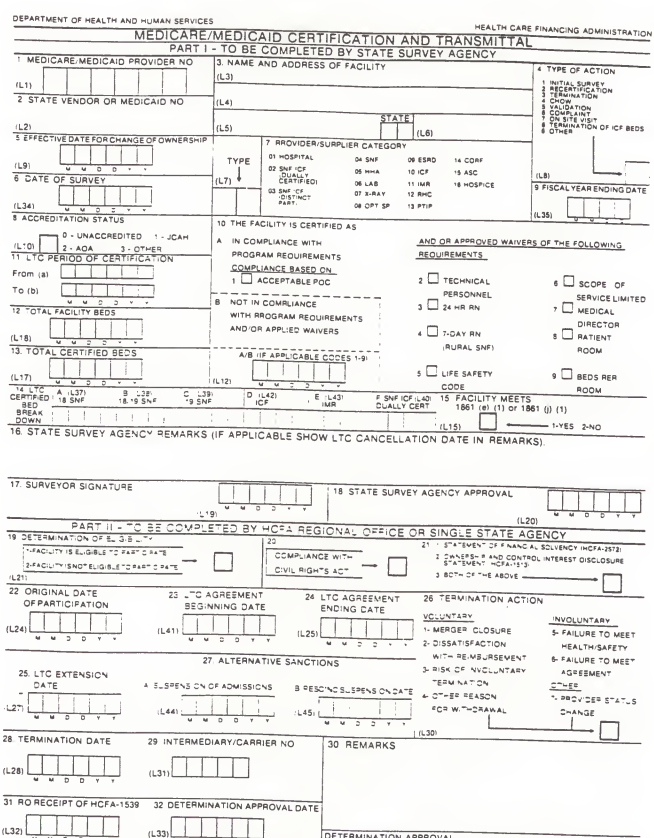
   This system records the identity of corporations/partnerships that own and operate chains of certified providers. Revised SRF forms will capture relevant data, and this will become a subsystem of the MMACS.

6. Case Control System

This system uses POS/SRF data to monitor Regional Office and State agency response to error correction and to control backlogs of surveys.

Recurring tabulations and analyses based on information from the POS file are published on an annual basis. Various listings and tabulations have been produced to satisfy requests from private organizations, other components of HCFA and DHHS, and the Congress. A version of the POS tape file is also prepared in a format suitable for use as input to the table generating software package, which is another means of servicing one-time special requests.

Exhibit A



DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY STATE SURVEY AGENCY

1 MEDICARE/MEDICAID PROVIDER NO (L1)

2 STATE VENDOR OR MEDICAID NO (L2)

3. NAME AND ADDRESS OF FACILITY (L3) (L4) (L5) STATE (L6)

4 TYPE OF ACTION
1 INITIAL SURVEY
2 RECERTIFICATION
3 TERMINATION
4 CHOW
5 VALIDATION
6 COMPLAINT
7 ON SITE VISIT
8 TERMINATION OF ICF BEDS
9 OTHER (L8)

5 EFFECTIVE DATE FOR CHANGE OF OWNERSHIP (L9) M M D D Y Y

6 DATE OF SURVEY (L34) M M D D Y Y

7 PROVIDER/SUPPLIER CATEGORY — TYPE (L7)
01 HOSPITAL 04 SNF 09 ESRD 14 CORF
02 SNF/ICF (DUALLY CERTIFIED) 05 HHA 10 ICF 15 ASC
06 LAB 11 IMR 16 HOSPICE
03 SNF/ICF (DISTINCT PART) 07 X-RAY 12 RHC
08 ORT SP 13 PTI/P

9 FISCAL YEAR ENDING DATE (L35) M M D D

8 ACCREDITATION STATUS (L10) 0 - UNACCREDITED 1 - JCAH 2 - AOA 3 - OTHER

10 THE FACILITY IS CERTIFIED AS
A IN COMPLIANCE WITH PROGRAM REQUIREMENTS
COMPLIANCE BASED ON
1 ☐ ACCEPTABLE POC
B NOT IN COMPLIANCE WITH PROGRAM REQUIREMENTS AND/OR APPLIED WAIVERS
A/B (IF APPLICABLE CODES 1-9)

AND OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS
2 ☐ TECHNICAL PERSONNEL
3 ☐ 24 HR RN
4 ☐ 7-DAY RN (RURAL SNF)
5 ☐ LIFE SAFETY CODE
6 ☐ SCOPE OF SERVICE LIMITED
7 ☐ MEDICAL DIRECTOR
8 ☐ PATIENT ROOM
9 ☐ BEDS PER ROOM

11 LTC PERIOD OF CERTIFICATION
From (a) M M D D Y Y
To (b) M M D D Y Y

12 TOTAL FACILITY BEDS (L18) M M D D Y Y

13. TOTAL CERTIFIED BEDS (L17) M M D D Y Y

(L12) M M D D Y Y

14 LTC CERTIFIED BED BREAK DOWN
A (L37) 18 SNF
B (L38) 18/19 SNF
C (L39) 19 SNF
D (L42) ICF
E (L43) IMR
F SNF/ICF (L40) DUALLY CERT

15 FACILITY MEETS 1861 (e) (1) OF 1861 (j) (1) (L15) 1-YES 2-NO

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE IN REMARKS).

17. SURVEYOR SIGNATURE (L19) M M D D Y Y

18 STATE SURVEY AGENCY APPROVAL (L20) M M D D Y Y

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19 DETERMINATION OF ELIGIBILITY
1-FACILITY IS ELIGIBLE TO PART C RATE
2-FACILITY IS NOT ELIGIBLE TO PART C RATE (L21)

20 COMPLIANCE WITH CIVIL RIGHTS ACT

21 1 STATEMENT OF FINANCIAL SOLVENCY (HCFA-2572)
2 TRANSFER AND CONTROL INTEREST DISCLOSURE STATEMENT (HCFA-1513)
3 BOTH OF THE ABOVE

22 ORIGINAL DATE OF PARTICIPATION (L24) M M D D Y Y

23 LTC AGREEMENT BEGINNING DATE (L41) M M D D Y Y

24 LTC AGREEMENT ENDING DATE (L25) M M D D Y Y

26 TERMINATION ACTION
VOLUNTARY
1- MERGER CLOSURE
2- DISSATISFACTION WITH REIMBURSEMENT
3- RISK OF INVOLUNTARY TERMINATION
4- OTHER REASON FOR WITHDRAWAL
INVOLUNTARY
5- FAILURE TO MEET HEALTH/SAFETY
6- FAILURE TO MEET AGREEMENT
OTHER
7- PROVIDER STATUS CHANGE
(L30)

27 ALTERNATIVE SANCTIONS

25. LTC EXTENSION DATE (L27) M M D D Y Y

A SUSPENSION OF ADMISSIONS (L44) M M D D Y Y

B RESCIND SUSPENSION DATE (L45) M M D D Y Y

28. TERMINATION DATE (L28) M M D D Y Y

29 INTERMEDIARY/CARRIER NO (L31)

30 REMARKS

31 RO RECEIPT OF HCFA-1539 (L32) M M D D Y Y

32 DETERMINATION APPROVAL DATE (L33) M M D D Y Y

DETERMINATION APPROVAL

FORM HCFA-1539 (7-84) (DESTROY PRIOR EDITIONS)

1. HCFA REGIONAL OFFICE

IV. Bill Records from Institutional Providers

Introduction

This chapter describes the statistical files created from bills submitted by institutional providers. These are primarily hospitals, skilled nursing facilities, home health agencies, rural health clinics, and renal dialysis facilities. They provide Medicare services for both Part A and Part B of the program. They submit their bills to HCFA by way of the Part A intermediary selected by them to process their claims.

HCFA has the basic responsibility for controlling and monitoring intermediary/carrier payments to beneficiaries or providers. Intermediaries and carriers are responsible for verifying a beneficiary's eligibility, type of coverage, deductible, etc., before a claim is paid. When a beneficiary is admitted as an inpatient to a hospital or skilled nursing facility, the provider must determine if hospital entitlement exists. The provider notifies their servicing intermediary of the admission at the time it submits a bill. the intermediary then submits the admission data to HCFA. HCFA's query system processes these queries against its Health Insurance Master file to determine the beneficiary's status. If the beneficiary is covered, HCFA will then prepare an admission notice for in-house subsequent processing and will also transmit a query reply that is used by the intermediary to update its own history files.

Preparation of the Query Record

A query (admission) record must be submitted by the intermediary for all Medicare beneficiary inpatient or skilled nursing facility (SNF) admissions. This is needed by HCFA to maintain accurate benefit period (spell-of-illness) information.

The notice of an inpatient hospital admission, when transmitted to HCFA results in recording the beginning of services in the patient's utilization record; i.e., the creation of an "open item". This open item remains on the individual's record until it is closed by a discharge bill. See Exhibit A for contents of the Admission Record.

Queries are also received by HCFA for Supplementary Medical Insurance (SMI) claims. However, after the carrier has verified the beneficiary's entitlement and deductible status, if the deductible is met, subsequent claims are not normally queried. SMI claims involving non-inpatient psychiatric or physical therapy expenses must be queried unless the carrier has information in file from a previous reply indicating that the applicable money limits have been reached. Since current statistics are not being obtained from SMI queries, this manual does not cover those records.

Approximately 11,000,000 admission notice (or query) records are received annually.

One Hundred Percent Files

Provider bills submitted by intermediaries to HCFA enter the statistical system only after they have been updated to the Health Insurance Master record (HIM). When the bill records are updated to the HIM, the enrollees' demographic characteristics such as age, sex, race, and residence are appended. These records, which now contain both billing and demographic information, are cumulated weekly and then entered into the statistical system.

Exhibits B, C, D, and E contain record formats of the bill records which comprise the one hundred percent bill files. The bill records are extracts of the provider submitted HCFA-1450 (UB-82, Uniform Bill) shown as exhibit F. The record formats are as follow:

Exhibit B - Inpatient Hospital and Skilled Nursing Facility Record Format. This record contains information from Part A inpatient hospital and inpatient skilled nursing facility bills.

Exhibit C - Home Health Agency Record Format. This record contains Part A and Part B HHA billing information. If a bill contains both Part A and Part B information, two separate tape records are prepared.

Exhibit D - Outpatient Bill Record Format. This record contains Part B outpatient billing information. It is also used for rural health clinic and outpatient renal dialysis services.

Exhibit E - Hospice Record Format. This record contains information on hospice services rendered.

The one hundred percent provider bill files, along with the one hundred percent file of payment records, are used to prepare control tables and a series of monthly, quarterly, semi-annual, and annual tabulations. Some tables are based on all of the records and others are based on samples which are inflated.

Diagnostic and Surgical Procedure Data

In addition to the one hundred percent utilization bill files described above, there are files containing diagnostic and surgical procedure codes. These are reported directly by the intermediary from provider submitted codes. The information on each type of bill is as follows:

Inpatient Hospital - Principal diagnosis and principal surgical procedures (if any)

Inpatient SNF - Admitting diagnosis

Outpatient Hospital - Nature of illness and surgical procedure (if any)

Home Health Agency - (A or B) - Diagnosis

Prior to October 1983, the diagnostic and surgical information was reported in narrative form (up to 45 characters for diagnosis and 41 characters for surgery) for samples of bills only. Only one diagnosis and surgical procedure (if any) was coded. The coding system in use since 1979 is ICD-9-CM Volumes I and II for diagnosis and ICD-9-CM, Volume III, for surgical procedures. For services before 1971, ICDA-7 was used; and from 1971 - 1978, it was ICDA-8.

In October 1983, hospitals were required to report only ICD-9-CM codes for inpatient hospital bills. Narratives were no longer permitted. Inpatient hospital bills were to contain codes for the principal diagnosis and up to four additional diagnoses and principal surgical procedure and up to two additional surgical procedures, if any.

Inpatient hospital bills also were required to contain a Diagnosis Related Group (DRG) number to determine reimbursement for prospective payment. The DRG is assigned by the fiscal intermediary by processing the billing information through a computer program called GROUPER.

Medicare bills other than inpatient hospital, outpatient, home health, and skilled nursing facility were still reporting either narratives or codes until April 1985 when only ICD-9-CM codes were permitted. Beginning July 1, 1987 outpatient surgery codes were required to be reported using HCFA Common Procedure Coding System (HCPCS) codes.

Annual Volume of Records for the One Hundred Percent Files - 1987

1. Inpatient Bills - 11 Million
2. Home Health Agency Bills - 5 Million
3. Outpatient Bills - 42 Million
4. Skilled Nursing Facility Bills - 0.8 Million

These bill records, along with approximately 360 million Part B Payment Records, are on monthly files based on month processed in HCFA. Each monthly file contains all types of bills in sequence by processing week and Health Insurance Claim Number and comprises approximately 60 reels of magnetic tape.

Exhibit A

Part A (Query) Admission Notice Contents

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Admission Date	Julian date beneficiary admitted as inpatient to hospital or SNF.
3.	Query Code	-Initial request -Delete previous request -Follow-up request -Status request
4.	Beneficiary Name a. Surname b. First Initial c. Middle Initial	First six letters of surname
5.	Date of Birth	Julian date of beneficiary's birth
6.	Sex	-Male -Female -Unknown
7.	Type of Facility	-Christian Science SNF -Psychiatric -TB -General Care -Regular SNF
8.	Receipt Date	Date admission notice was received into the HCFA EDP system.
9.	Process Date	Date admission notice was processed.
10.	Disposition Code	This code identifies the type of reply made by HCFA to the intermediary. Codes basically indicate approval, rejection, qualified approval, or just an acknowledgement of the receipt of the admission notice.
11.	Reason for Entitlement Trailer Code	-No disability or ESRD involvement. -Beneficiary currently insured due to disability. No ESRD involvement.

	Information	Description
33.	Primary Payor Code (con.)	-Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers' Compensation including black lung -VA, PHS, or other federal agency -Medicare is primary payor
34.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor. Zero for Medicare.
35.	Value Code	Description and codes are contained in the Glossary.
36.	Value Code Amount	Amount related to the value code.
37.	Revenue Center Code	Code identifying each service incurred during the billing period.
38.	HCPCS Procedure Code	Clinical laboratory charges for non-inpatient services reimbursed at 100 percent.
39.	Units	
40.	Service Date	MMDD - May be zeroes.
41.	Rate	
42.	Covered Charges	
43.	Professional Pathology Charges	Amount paid for hospital inpatient or other professional components.
44.	Professional Radiology Charges	Amount paid for hospital inpatient or other professional components.
45.	Professional Other Charges	Amount paid for hospital inpatient or other professional components.
46.	Blood Deductible	
47.	Blood Deductible Pints	Number of whole pints of blood
48.	Cash Deductible	

	Information	Description
49.	Coinsurance Amount	Comprehensive Outpatient Rehabilitation Facility (CORF) only
50.	Blood Pints Furnished	Number of whole pints furnished.
51.	Blood Pints Replaced	
52.	Blood Pints Not Replaced	
53.	Blood Charge/Pint	Zero if no charge for blood. UNIBILL - Constant zero.
54.	Patient Paid for Blood Deductible	
55.	ESRD Method of Reimbursement	-Not ESRD -Method 1 -Method 2
56.	Special Service Code	-Professional component -Durable medical equipment -Home dialysis equipment -Pneumococcal vaccine
57.	Charges Excluded From Deductible	UNIBILL only, accumulation of amounts for revenue center charges which are not subject to deductible.
58.	Number of Diagnosis	Number of diagnostic codes attached.
59.	Diagnosis Code	Nature of illness code based on ICD-9-CM, Volumes I and II.
60.	Additional Diagnoses	Up to 4 additional ICD-9-CM Volumes I and II diagnosis codes.
61.	Date of Surgery	Format YYDDD. Date of beneficiary's surgery.
62.	Number of Surgical Procedures	Number of surgical codes.
63.	Surgical Procedure Code	Procedure codes based on ICD-9-CM, Volume III. Effective July 1, 1987 HCPCS codes replace the ICD-9-CM Volume III codes for outpatient surgery.

Information	Description
64. Additional Surgery	Same as field 63. Up to two additional codes.
65. Patient Paid Amount	
66. Amount Paid to Provider	
67. Amount Paid to Patient	
68. Date Benefits Exhausted	Format YYDDD. Julian date.
69. Date Plan Terminated	Format YYDDD. Julian date.
70. Total Charges	Total charges for all services
71. Reimbursement Amount	Sum of amount paid to provider and amount paid to patient fields.

Exhibit E

Hospice Bill Records

	Information	Description
1.	Health Insurance Claim Number	Number that identifies the beneficiary.
2.	Beneficiary Identification Code	Identifies beneficiary's relationship to SSN. For bill and stay records this field is an equatable BIC.
3.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number.
4.	Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5.	State Code of Residence	SSA standard State code.
6.	County Code of Residence	SSA standard county code.
7.	Date of Birth	Format YYDDD. Julian date. Date of beneficiarys birth (from Master Record).
8.	Sex Code	Code which identifies the sex of the beneficiary (from Master Record). -Unknown -Male -Female
9.	Race Code	Code which identifies the race of the beneficiary (from Master Record). -Unknown -White -Black -Other
10.	ZIP Code of Residence	Beneficiary's ZIP code from Master Record.
11.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

V. Stay Records

Introduction

The Inpatient Hospital Stay Record contains information about a person's stay in a hospital from admission through discharge for 100 percent of Medicare enrollees. Stay records are used to compile a very large portion of the health insurance utilization statistics such as the annual short-stay hospital tabulations, current utilization tabulations, and Medicare Provider Analysis and Review (MEDPAR) files. This record contains utilization information from bills, demographic information about the enrollee, and provider information. The file contains about 11,000,000 records per year.

Billing and Demographic Information

The basic input for the hospital stay records are bills for inpatient hospital services submitted to HCFA via intermediaries for Medicare payments by hospitals. Bills which have cleared the administrative process at HCFA and have been updated to the Health Insurance Master File (HIM) are entered into the statistical system. When the bill record is updated to the HIM, the enrollee's demographic characteristics such as date of birth, sex, race, and State, county and zip code of residence are appended to it. The record sent for statistical processing contains both the billing information and a person's demographic characteristics. Chapter IV describes the contents of these records.

All bills submitted for the same hospital stay are sorted and summarized, creating a bill summary record. When the bill summary indicates that the patient has been discharged (i.e., a discharge bill has been received), a stay record showing information from date of admission to date of discharge is created. A single bill, in approximately 95 percent of all cases, will result in a completed stay record. If the patient has not been discharged, the bill summary remains on an orbiting bill summary file until the discharge information is received. The stay record is in the same format as the inpatient hospital and skilled nursing facility record format shown in Chapter IV, Exhibit B.

Bills used for creating stay records contain a principal diagnosis code and an indication of whether or not there were additional diagnoses. The five digit diagnostic code is assigned from the ICD-9-CM, Volumes I and II. If surgery has been performed, a principal surgical procedure code, and indication of additional surgical procedures, and a date of surgery are also shown on the bill. The four digit surgical procedure code is assigned from the ICD-9-CM, Volume III. Codes, for up to four additional diagnoses and up to two additional surgical procedures may be shown. There is also a Diagnosis Related Group (DRG) number.

SNF Stay Records

Stay records are also prepared for stays in Skilled Nursing Facilities. The SNF stay record is essentially the same as the hospital record. SNF stay records contain an admitting diagnosis instead of the principal diagnosis, and there is no surgery. The five digit admitting diagnosis code is assigned from the ICD-9-CM, Volumes I and II as is the inpatient hospital bill principal diagnosis. There are also dates of admission and discharge of the qualifying hospital stay. The record format is the same as the inpatient hospital and skilled nursing facility record format shown in Chapter IV, Exhibit B.

Derivative Files

Exhibit A contains the contents of the MEDPAR (Medicare Provider Analysis and Review) record. The MEDPAR record is derived from the inpatient hospital stay record. Each record contains selected items of information from the hospital stay record. The file of MEDPAR records is prepared every 3 months and contains 3 years of discharges, the current year and 2 previous years. For example, the file created at the end of July 1986 contains discharges from 1984 through 1986. Annually, approximately 11.0 million records are created.

Exhibit B contains the contents of the MEDPAR Public Use File. This file contains selected data fields extracted from the MEDPAR records. Personal identifiers are omitted to enable use for non-HCFA purposes. The MEDPAR and the MEDPAR Public Use File are available in fiscal or calendar year format.

MEDPAR File

1.	HI Claim Number	Actual Number
2.	Age	Age as of last birthday on date of admission.
3.	Sex	Sex code obtained from HI Master Record. -Unknown -Male -Female
4.	Race	Race code obtained from HI Master Record. -Unknown -White -Black -Other
5.	Medicare Status Code	Code to show reason for beneficiary's entitlement. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
6.	State and County of Residence	SSA state and county code of residence.
7.	ZIP Code of Residence	Actual code
8.	Day of Admission	Day of admission to provider. -Sunday -Monday -Tuesday -Wednesday -Thursday -Friday -Saturday
9.	Discharge Status	Discharge Status -Alive -Dead
10.	HMO Readmission Indicator	-Not paid by HMO -Paid by HMO -Readmission within 7 days -Both conditions present

Exhibit A

	Information	Description
11.	PPS Indicator	Hospital being paid under a prospective payment system. -Yes -No
12.	Provider Number	Identification number of provider.
13.	Provider Code	Code to identify components of inpatient hospitals. -Original provider number as is -Psychiatric Unit -Rehabilitation Unit -Swing - Bed Hospital Designation -Alcohol Drug Unit
14.	Date of Admission	YYDDD (YY=Year, DDD=Julian Day)
15.	Date of Discharge	YYDDD (YY=Year, DDD=Julian Day)
16.	Length of Stay	Date of discharge minus date of admission. If difference was 0, it was made 1.
17.	Covered Days	The number of days covered by Medicare.
18.	Coinsurance Days	The inpatient medicare days occurring after the 60th day and before the 91st day in a single spell of illness.
19.	Coinsurance Amount	$$$$$ - Total amount for coinsurance.
20	Inpatient Deductible	$$$ - Deductible to be paid by patient.
21.	Lifetime Reserve Days Used	Under medicare each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
22.	Total Charges	$$$$$$ - Dollars only

	Information	Description
23.	Covered Charges	$$$$$$ - Dollars only
24.	Amount Reimbursed	$$$$$$ - Dollars only
25.	Intensive Care Days	Days
26.	Coronary Care Days	Days
27.	Total Accommodation Charges	$$$$$$ - Dollars only
28.	Total Departmental (Ancillary) Charges	$$$$$$ - Dollars only (Summary Total)
29.	Intensive Care Charges	$$$$$$ - Dollars only
30.	Coronary Care Charges	$$$$$$ - Dollars only
31.	Operating Room Charges	$$$$$$ - Dollars only
32.	Pharmacy Charges	$$$$$$ - Dollars only
33.	Laboratory Charges	$$$$$$ - Dollars only
34.	Radiology Charges	$$$$$$ - Dollars only
35.	Supplies Charges	$$$$$$ - Dollars only
36.	Anesthesia Charges	$$$$$$ - Dollars only
37.	Inhalation Therapy	$$$$$$ - Dollars only
38.	Outpatient Service	$$$$$$ - Dollars only
39.	Blood Administration	$$$$$$ - Dollars only
40.	Physical Therapy	$$$$$$ - Dollars only
41.	Occupational Therapy	$$$$$$ - Dollars only
42.	Speech Pathology	$$$$$$ - Dollars only
43.	Other Charges	$$$$$$ - Dollars only

	Information	Description
44.	Diagnostic Data	Principal and up to four additional ICD-9-CM Volumes I and II diagnosis codes.
	A. Number of Codes	Number of diagnostic codes.
	B. Codes	Five position diagnostic codes; left justified, blank filled.
45.	Surgery Indication	-Yes -No
46.	Inpatient Data (Surgical Data)	
	A. Surgical Date 1	YYDDD -Date 1st surgical procedure performed. Zero if date not submitted.
	B. Number of Codes	Number of surgical codes.
	C. Codes	Four position ICD-9-CM volume III surgical codes; left justified, blank filled.
	D. Surgical Date 2	YYDDD - Date 2nd surgical procedure performed. Zero if date not submitted.
	E. Surgical Date 3	YYDDD - Date 3rd surgical procedure performed. Zero if date not submitted.
	SNF Data (Inpatient Surgical Data Area Redefined)	
	A. SNF date benefits exhausted	YYDDD
	B. Filler	Reserved
	C. SNF Indicator	Value "SNF" Indicating SNF Record
	D. Filler (Occurs Two Times)	Reserved
	E. Dates of Qualifying Stay for SNF Facility	
	1. From Date	YYDDD - Beginning Date of Stay
	2. Through Date	YYDDD - Ending Date of Stay

	Information	Description
47.	Blood Furnished (pints)	2-digit whole pints.
48.	Original BIC	This is the original BIC of the HIC number on the bill or payment record,which has been replaced with the equatable BIC.
49.	DRG Code	Code assigned to indicate the diagnosis related group to which this claim belongs for payment purposes.
50.	Discharge Destination	Code to indicate destination of patient at time of discharge: -To home, self care -To short-term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Died -Still patient
51.	Outlier Code	Code indicating whether covered days or charges exceed the threshold values. Also used to code DRG information. -No outlier -Day outlier -Cost outlier -Valid DRG received from the intermediary -HCFA developed DRG -HCFA developed DRG using Patient -Status code -Not groupable
52.	Primary Payor Code	Code indicating who is primarily responsible for payment. -Working aged beneficiary/spouse with employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected

Exhibit A

	Information	Description
52.	Primary Payor Code (con.)	-Automobile no-fault or any liability insurance -Worker's Compensation including black lung -VA, PHS or other federal agency -Medicare is primary payor
53.	Type of Admission	Code indicating type of Admission. -Emergency -Urgent -Elective -Newborn -Unknown
54.	Source of Admission	Code indicating source of admission: -Physician referral -Clinic referral -HMO referral -Transfer from hospital -Transfer from SNF -Transfer from another health care facility -Emergency room -Court/Law enforcement -Unknown -Normal delivery -Premature delivery -Sick baby -Extramural -Unknown
55.	Professional Components	Dollars only - Amount for hospital inpatient or other professional components.
56.	Blood Charges	Dollars only - Charges for blood usage.
57.	Unibill Indicator	Code indicated unibill format or not unibill format.
58.	Primary Payor Amount	$$$$$$ - Dollars only. Medicare covered amount paid by primary payor. Zero filled for Medicare.
59.	Intermediary Number	Identification number of intermediary processing the bill.

	Information	Description
60.	Query Code	Code indicating type of bill submitted: -Credit Adjustment -Interim -Final -Discharge Notice -Debit Adjustment
61.	Active Care Ended Date	YYDDD (YY=Year, DDD=Julian Day)
62.	Outlier Amount	$$$$$$ - Dollars only Additional reimbursement amount approved due to an outlier situation.
63.	Kidney Acquisition Charge	$$$$$ - Dollars only
64.	Outlier Days	Number of outlier days used.
65.	DRG Price	$$$$$$ - Dollars only
66.	New DRG Code	Grouper 3.0 (May 1, 1986-September 30, 1986). Grouper 4.0 (October 1, 1986). Grouper 5.0 (November 11, 1987)
67.	New Outlier Days	Number of outlier days used based on the grouper used.
68.	HI Master Date of Death	YYDDD (YY=Year, DDD=Julian Day) Date taken from the HI Master File.
69.	HI Master Date of Death Indicator	-Nonvalid Date of Death -Valid Date of Death
70.	New Change Indicator	-No Change to Record -New Record -Change Record
71.	Total Pass Through	
	a. Total Per Diem	-Covered Days multiplied by Per Diem
	b. Total Indirect Medical Education Amount (IME)	-Amount Reimbursed multiplied by IME Cost Rate
	c. Kidney Acquisition Charge	-For DRG 302 Only

Exhibit B

MEDPAR Public Use File

Information		Description
1.	Diagnosis Related Group (DRG)	Code assigned to indicate the DRG to which this claim belongs for payment purposes.
2.	Major Diagnostic Categories (MDC)	Identifies the category of which the DRG is a member.
3.	Medicare Status Code	Code indicating the reason for entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
4.	Day of Admission	Day of admission to provider: -Sunday -Monday -Tuesday -Wednesday -Thursday -Friday -Saturday
5.	Discharge Status	Discharge Status: -Alive -Dead
6.	Metropolitan/Nonmetropolitan	Codes to identify metropolitan areas designated by Statistical Area (MSA/NONMSA) Executive Office of Management and Budget (OMB) Codes that have populations of 50,000 or greater.
7.	Length of Stay	Date of discharge minus date of admission. If difference is 0, it is made 1.
8.	Covered Days	The number of days covered by Medicare.
9.	Total Charges	$$$$$$ - Dollars only

VI. Part B Payment Records

Introduction

Part B Supplementary Medical Insurance (SMI) benefits are payable for physician's services, home health service visits, outpatient hospital services, and other medical services and supplies. Medical insurance benefits for home health services and outpatient hospital services, where the bills are processed by a Part A Intermediary, are covered in other chapters. This chapter relates to physician services and other medical services and supplies where the requests for payment are processed by Part B carriers. Payments are generally made on a charge basis and are generally subject to both an annual deductible amount and a coinsurance amount. Specific medical services not subject to any deductible or coinsurance amounts are detailed in the "Preparation of the Payment Record" portion of this chapter. Payments for services can be made directly to a physician (or other supplier of medical services) if they accept assignment or to the beneficiary if assignment is not accepted by the physician or supplier. Basically Forms HCFA-1500/1490S are the basic Part B claim forms used by either the patient or physician (supplier) to claim reimbursement. (Form HCFA-1490 was used prior to Forms HCFA-1500 or HCFA-1490S). See Exhibits C-D for copies of these forms.

HCFA, which has the basic responsibility for administering the SMI program, enters into agreements with public or private organizations which serve as carriers to help administer the medical insurance benefit claims process. These contractor organizations, using HCFA coverage and claims processing guidelines, determine which services are covered, the amounts payable, and make payment to providers and beneficiaries. They also communicate utilization and benefit information to HCFA.

Carriers prepare and send to HCFA a payment record for every bill for which reimbursement is made under the Supplementary Medical Insurance Program. The payment record has very important administrative and statistical uses.

1. To provide current information on supplementary medical insurance benefit payments and to make possible the preparation of a variety of operating statistics.

2. To provide information to assist in the conduct of administrative and fiscal audits of carrier operations.

3. To draw samples for special ad hoc studies focusing on specific groups of physicians and suppliers, specific types of services, and specific geographic areas.

4. To provide current information to assist in preparing a variety of program statistics tabulations.

5. To provide a 100 percent base from which either samples or 100 percent files may be used to provide data needed for actuarial calculations.

Because of their importance, all carriers prepare payment records uniformly in accordance with the instructions contained in the Medicare Carrier's Manual and transmit them promptly to HCFA.

The Office of Health Program Systems (OHPS) handles the automated processing of payment records and has the responsibility to determine the appropriateness of payments made by carriers based on a computer analysis of the data contained in the payment records and the related Health Insurance Master Record data. Entitlement to benefits during the period in which expenses were incurred, deductible satisfied, proper computation of the reimbursable amount, etc., are monitored in the data edit/validation processes. Inconsistencies detected are returned to the carriers for investigation, correction, and resubmission. A "suspense" file of all rejected records is maintained by OHPS to ensure their return. As these records are corrected and returned, they are deleted from the suspense file and processed in the utilization routines.

Preparation of the Payment Record

A payment record is prepared by a carrier after the amount of reimbursement on an individual bill has been determined and payment has been made to the physician or the beneficiary (or on his or her behalf). A "bill" is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or single supplier. A payment record is submitted for every bill for which reimbursement is made. Payment records are also prepared for bills where the primary payor is other than Medicare. Situations will arise--e.g., overpayments or incomplete information--where carriers determine that the amount reimbursed for a specific bill is incorrect and needs to be adjusted. In those instances, a corrected payment record is submitted.

The number of bills on a request for payment is determined by the number of different beneficiary-physician (or supplier) relationships represented. For example, a request for payment accompanied by itemized statements from only one physician or supplier constitutes only one bill, regardless of the number of occasions of service. A request for payment accompanied by itemized statements from two physicians or suppliers constitutes two bills, etc.

The definition of a payment record is generally the same as that of a bill. A request for payment from a beneficiary accompanied by one or more itemized statements from the same physician requires preparation of only one payment record. On the other hand, if a beneficiary had accumulated and submitted itemized statements from two physicians for medical treatment and from an orthotist for fitting and purchase of an artificial leg and reimbursement was made for the services of all three, the carrier prepares three payment records--one for each physician's services and one for the orthotist's services.

Separate payment records are prepared when a bill is submitted for services rendered in different calendar years in each of which the deductible had been met and reimbursement made.

Separate payment records are also prepared for bills submitted covering specific services requiring special payment procedures designated by Amendments to the Medicare Law. These services include:

1. Hospital-based Radiologist and Pathologists

Effective October 1, 1982, inpatient radiology and pathology services became reimbursable on the same basis as for other physician services, i.e., 80 percent of the reasonable charge after the Part B deductible has been met.

Prior to October 1982, Medicare reimbursed these services at 100 percent of reasonable charges with no deductible or coinsurance applied.

2. Diagnostic Laboratory Fees Reimbursed at a Negotiated Rate

Beginning June 30, 1984, services performed in a laboratory that are billed on an assignment basis may be reimbursed at 100 percent of a negotiated rate with no coinsurance applied; however, payments made are subject to the annual deductible. This applies only to those laboratories which have negotiated a rate agreement with the carrier.

3. Independent Physical Therapists

Beginning July 1, 1973, services performed by an independent physical therapist in the therapist's office or in the patient's home became covered up to a maximum of $100 a year. This was increased to $500 a year effective January 1, 1982. A separate payment record is prepared for each bill for services performed by an independent therapist until the maximum expense has been incurred.

4. Physician Services Provided to Living Kidney Donors

Beginning October 1, 1978, physician services provided to living kidney donors are reimbursed at 100 percent. These services include monies for both the kidney donation surgery and the post-operative recovery period. These services are billed to the program under the name and HI Claim Number of the recipient.

5. Used Durable Medical Equipment (DME)

Beginning November 1, 1977, the purchase of used DME became reimbursable at 100 percent of the reasonable charge less any deductible yet to be met. The used DME charge, however, cannot exceed 75 percent of the cost of new DME.

6. Pneumococcal Vaccine

Effective July 1, 1981, carriers were authorized to reimburse beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine. Both deductible and coinsurance will be waived for this service.

7. Ambulatory Surgical Center

Beginning September 7, 1982, certain services performed in an Ambulatory Surgical Center or in a hospital outpatient setting that are billed on an assignment basis may be reimbursed at 100 percent of the reasonable charge. Reimbursement in this manner is not subject to the deductible or coinsurance.

NOTE: Although separate payment records are prepared for the above types of service, the beneficiary, physician, and calendar year relationship must still exist in all payment records produced.

Whenever payment is made for purchase of durable medical equipment, a payment record is also prepared. If the payments are spread out over a period of months, a payment record is also prepared for each payment even though monthly bills are not submitted.

The 1967 Amendments established, effective January 1, 1968, a separate Part B blood deductible. This deductible is equal to the charge for the first three (3) pints of blood furnished an individual in a calendar year. When a Request for Payment is received for blood charges, no payment record is prepared if those charges represent blood used to satisfy the Part B blood deductible. Charges for blood after the blood deductible has been satisfied and for which payment is made requires the preparation of a payment record.

Deviations are not made from the procedures discussed above for preparing payment records on a "bill" basis. In addition, the format of the payment records and codes to be used for individual fields must conform exactly to those detailed in Exhibit A.

Contents of the Payment Record

For purposes of this manual, a description of payment records used in statistical programs is available in Exhibit A. Carriers code all fields, using the same coding criteria and periodically submit records on magnetic tape. Each record contains beneficiary and physician identification with reasonable charges and reimbursement amounts. Statistical data includes type and place of service, specialty code of the physician/supplier, and month and year of service.

Approximately 360 million payment records are received annually.

Procedure File

Information		Description
1.	Procedure Code	The 5-digit HCPCS code as recorded in carrier history or converted history.
2.	Modifier	The HCPCS 2-digit modifier. If multiple modifiers are reported, the initial modifier is shown.
3.	Specialty	The HCFA 2-digit code showing the type of specialty of the physician/supplier providing the service.
4.	Carrier Number	HCFA assigned identification code
5.	Locality	This two digit code identifies the pricing locality used.
6.	Type of Service	This field represents the type of service. -Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Whole Blood or Packed Red Cells -Used DME -Ambulatory Surgical Center (Facility Usage) -Hospice -Purchase of DME (Installment) -Renal Supplies in the Home -Monthly Capitation Payment (Dialysis) -Kidney Donor -Purchase of DME (Lump Sum Payment) -Rental of DME -Pneumococcal Vaccine -Surgical Second Opinion -Surgical Third Opinion

7.	Place of Service	This field denotes the place of service. -Office -Home -Inpatient Hospital -SNF -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center -Ambulatory Surgery Center -Hospice -Nursing Home
8.	Second Modifier	-If multiple modifiers are used to determine allowed charges, the second modifier is shown.
9.	Region Code	This is a 2 digit code to identify HHS Regions.
10.	Frequency	An unduplicated count of the total number of times that this procedure code/modifier occurred within this locality, specialty, T/S, P/S sequence as reported by or on behalf of, a beneficiary. Duplicates or adjustments to initial line items are not included.
11.	Miles/ Time/ Units/ Services	The total number of miles (or units) used in calculating allowed charges for covered transportation, or
	(MTUS)	the total number of anesthesia units used in calculating allowed charges for covered anesthesia services, or
		the total number of units (pts.) of blood allowed, or
		the total number of cubic feet (or pounds) of oxygen used in calculating allowed charges for covered oxygen services or

Information	Description
11. Miles/Time Units/Services (con.)	the number of services used in calculating allowed charges for allowed physician/supplier services.
12. MTUS Indicator	This field denotes the type of MTUS. -Ambulance Miles -Anesthesia time units -Services -Oxygen units -Blood units -Anesthesia base and time units -No allowed activities
13. Submitted Charges	Total of submitted charges from all line items for this service included in the Frequency Field rounded to nearest dollar.
14. Allowed Charges	Total of all allowed charges from all accepted line items (including deductible) for this service and then rounded to nearest dollar.
15. Denied Frequencies	The number of times that the frequency counted in the Frequency field has been denied in full because: claimant ineligible, filing limitations exceeded, services not covered, or services not medically necessary. Duplicates or adjustments are not included.
16. Amount Denied	Total of the submitted charges from all line items shown in Denied Frequency field and rounded to nearest dollar.
17. Edit Exclusions	The total number of frequencies that represent adjustment actions, duplicate bills or other types of actions that are not included in Frequency field.
18. Amount of Exclusions	The dollar value of the submitted charge for all services in Edit Exclusion field above rounded to nearest dollar.
19. Services Assigned	The number of times the frequency shown in Frequency field was provided on assignment.

Exhibit A

Information		Description
20	Initial Modifier Unit	Anesthesia services only. Aggregrated total number of units by the initial modifier.
21.	Second Modifier Unit	Anesthesia services only. Aggregrated total number of units by the second modifier only.
22.	Base Unit	Anesthesia services only. Aggregated base units only.
23.	Ambulatory Surgical Center (ASC)	Surgical Procedures -Ambulatory Surgical Center (100% Reimbursement) -Nonambulatory Surgical Center

Prevailing Charge File

This file provides charge data generated by each carrier for each service during the Reasonable Charge update process.

Information		Description
1.	Procedure Code	The 5-digit HCPCS code for every service recorded on this file.
2.	Initial Modifier	The HCPCS 2-digit modifier that results in a separate prevailing charge. If multiple modifiers are reported, the initial modifier is shown.
3.	Second Modifier	If multiple modifiers are used to determine prevailing charges, the second modifier is shown.
4.	Specialty	HCFA specialty code.
5.	Carrier Number	HCFA assigned identification code.
6.	Locality	This two digit code identifies the pricing locality used.
7.	HCFA Type of Service	HCFA defined type of service.
8.	Pricing Type of Service	Type of service code used for profile development.
9.	Pricing Specialty	Specialty code used for profile development.
10.	Region Code	This is a 2 digit code to identify HHS Regions.
11.	Relative Value	-Relative Value Unit (RVU), or -Relativity not Established (RNE), or -By Report, where individual consideration is used to price the service.
12.	Conversion Factor	The Prevailing Charge conversion factor (CF) that is appropriate for this service.

Information		Description
13.	50%	The 50% percentile value calculated for this service.
14.	75%	The unadjusted prevailing charge for this locality and specialty that was calculated for this service.
15.	Origin	The origin of the data used to calculate the 75th percentile unadjusted prevailing charge. -75th percentile "N/A" -Medicare data only -Private business and Medicare -Other data -Private business only -Medicaid only -Medicare and Medicaid -Medicare, Medicaid, and private business
16.	Gap Fill Prevailing Charge	Coded only if unadjusted prevailing charge (75%) does not contain a calculation, the gap-fill unadjusted prevailing charge which will be used in the claims processing sequence. Where insufficient data exists to calculate a value, "RVU" is shown.
17.	Source of Gap Fill	Coded to indicate source: -Locality by specialty -Carrier wide/by specialty -Locality/no specialty -Carrier wide/no specialty -Array of actual charges -Other calculated value -"RVU" shown in Gap Fill Prevailing charge to reflect that insufficient data are available to calculate a value. -Unknown

Information	Description
18. Adjusted 75% (Prevailing charge) (Participating Physicians and Suppliers)	The numeric value of the prevailing charge that will be used for payment determination, i.e., the actual unadjusted prevailing charge, the Economic Index (EI) adjusted prevailing charge or another screen value, whichever is less.
19. Source of Adjustment (Participating Physicians and Suppliers)	The source of the value shown in adjusted 75 percent participating physicians. -No charge adjustment was made to the prevailing charge or no prevailing charge value was calculated. -EI adjustment -Lowest charge adjustment -No roll back adjustment -Price list -Inherent reasonableness -Laboratory charge disposition - Lab fee schedule -Other -Comparability
20. MAPC	Maximum Allowed Prevailing Charge.
21. Medicare Frequency	Total number of times that this procedure code/modifier, locality, pricing specialty, pricing type of service was used in developing the Prevailing Charge.
22. Medicare Frequency Indicator	-Medicare services only used to develop prevailing charge. -Both Medicare and non-Medicare service counted in Medicare frequency.
24. Generated Indicator	BMAD internal use only.

Provider File

This file provides data for all services rendered by selected physicians/suppliers. Prior to the 1985 submittals the sample size was a one percent sample of all active physician/suppliers in a carrier's service area. For 1985 and later, the sample size was increased to five percent of those active in the calendar period, i.e., January through December. The sampling techniques were developed by HCFA and all physicians/suppliers initially selected must be retained and reselected in subsequent years if they are currently active.

Information		Description
1.	Provider ID Number	The SSN, EIN, or carrier assigned number is shown. Services of solo practicing physician/suppliers with more than one identifying number are combined. Group practices should show only services by the group provider ID.
2.	Procedure Code/MOD	The 5-digit HCPCS procedure code and modifier if any.
3.	Specialty	The two digit HCFA code of the physician/supplier providing the service.
4.	Type of Service	HCFA Type of Service. Coded same as Type of Service field of Procedure File.
5	Place of Service	HCFA Place of Service. Coded same as Place of Service field of Procedure File.
6.	First Expense Date	Julian date of first expense date.
7.	Carrier Control Number	Control number assigned to each claim.
8.	Record Number	3 digit number to create unique keys with identifying information in first 7 fields.
9.	Beneficiary Claim Number	The HICAN as recorded on the claims history.
10.	Carrier Number	HCFA assigned identification number.

Information		Description
11.	Locality	This is the two digit code used to identify the pricing locality used.
12.	Type of Provider	-Physician or suppliers reporting as solo practitioners. -Institutional Providers -Independent Lab -Clinics -Groups -Other Entities
13.	Region Code	HCFA region codes.
14.	Submitted Charge	Dollars and cents.
15.	Allowed Charge	Dollars and cents.
16.	Processing Indicator	Coded as follows: -Allowed -Both allowed and denied where a from-to service contains services that were denied -Denied -Reprocessed - adjustments based upon subsequent reprocessing of the claim -Other -Secondary Payor
17.	Assignment Indicator	Coded as follows: -Participating Provider -All covered and allowed expenses applied to deductible - participating provider. -Assignment accepted - nonparticipating provider -Assignment not accepted - nonparticipating provider -Assignment accepted but all covered and allowed expenses applied to deductible - nonparticipating provider -Assignment not accepted and all covered and allowed expenses applied to deductible - non-participating provider

Information		Description
18.	Reimbursement	Dollars and cents.
19.	Reimbursement Indicator	Indicates whether the amount shown in Reimbursement field represents service or claim.
20.	Date Paid	Julian date shown on benefit check or the EOMB.
21.	Last Expense Date	Julian date of last expense date.
22.	MTUS	Miles/Time/Units/ or number of services.
23.	MTUS Indicator	Coded same as MTUS indicator field of Procedure File.
24.	Payment Indicator	Coded to indicate which payment screen was used to determine the payment. -Non-payment -Actual Charge -Customary Charge -Prevailing Charge (adjusted, unadjusted, gap fill, etc.) -Other (including ASC facility fees, radiology and outpatient limits, -Lab Fee Schedule
25.	ESRD Indicator	Coded to identify beneficiary. -ESRD Beneficiary -Not ESRD Beneficiary
26.	Number of Physician/ Suppliers	The number of Physicians or Suppliers reporting under this ID number at the end of the calendar year.
27.	ZIP Code	5 digit zip code of Physician/Supplier ID Number.
28.	Old BIC Code	Original BIC sent by carrier.

Information		Description
29.	Physician/Supplier Indicator	-Physician/Supplier ID represents same Physician/Supplier, regardless of multiple locators. -Physician/Supplier ID represents one of multiple numbers used for same Physician/Supplier.
30.	Pricing TOS	Type of service code used for profile development.
31.	Second Modifier	Second modifier if multiple modifiers are used to determine allowed charges.
32.	Initial Modifier Unit	Anesthesia services only. Aggregated number of units represented by the initial modifier.
33.	Second Modifier Unit	Anesthesia services only. Aggregated number of units represented by the second modifier.
34.	Base Unit	Anesthesia services only. Aggregated base units allowed.
35.	Ambulatory Surgical Center Indicator	-ASC procedure reimbursed 100% -Non-ASC

Beneficiary File

This file contains a five percent sample of all beneficiaries in the carrier's history file. Sample is based on terminal digits of the HI claim number. All services rendered to the selected beneficiaries are included in this file. Line item detail is also received for all ESRD beneficiaries.

	Information	Description
1.	Beneficiary Claim Number	The HICAN as recorded on the claims history.
2.	Carrier Number	HCFA assigned identification number.
3.	Carrier Control Number	Control number assigned to each claim.
4.	Old BIC Code	Original BIC sent by carrier.
5.	Region Code	HCFA Region Code
6.	Multi-Record Indicator	-Multiple records -Single records
7.	NBR Line Item	-Number of line items contained in the record.
8.	Procedure Code/MOD	The 5-digit HCPCS procedure code and modifier if any.
9.	Type of Service	Coded same as Type of Service field of Procedure File.
10.	Specialty Code	The 2-digit HCFA code of the physician/supplier providing the service
11.	Provider ID Number	The SSN, EIN or carrier assigned number as shown. All services of solo-practicing physicians/suppliers who have been assigned more than one identifying number are combined. For group practice providers, only those services performed by that group provider ID are shown.

Information		Description
12.	Type of Provider	Same as for Type of Provider field of Provider File.
13.	Submitted Charge	Dollars and cents.
14.	Allowed Charge	Dollars and cents.
15.	Reimbursement Amount	Dollars and Cents.
16.	Reimbursement Indicator	Indicates whether the amount shown in Reimbursement Amount field represents service or claim.
17.	Place of Service	Coded same as Place of Service field of Procedure File.
18.	Date Paid	Julian date shown on benefit check or the EOMB.
19.	First Expense Date	Julian date of first expense date of service.
20.	Last Expense Date	Julian date of last expense date of service.
21.	MTUS	Miles/Time/Units/ or number of services.
22.	MTUS Indicator	Coded same as MTUS Indicator field of the Procedure File.

Exhibit D

Information	Description
23. Assignment Indicator	Coded as follows: -Participating Provider -All covered and allowed expenses applied to deductible - participating provider -Assignment accepted - nonparticipating provider -Assignment not accepted- nonparticipating provider -Assignment not accepted but all covered and allowed expenses applied to deductible - nonparticipating provider -Assignment not accepted and all covered and allowed expenses applied to deductible - nonparticipating provider
24. Processing Indicator	Coded as follows: -Allowed -Both allowed and denied where a from-to service contains services that were denied -Denied -Reprocessed - adjustments based upon subsequent reprocessing of the claim -Other -Secondary Payor
25. Payment Indicator	Coded to indicate which payment screen was used to determine the payment. -Non-payment -Actual Charge -Customary Charge -Prevailing Charge (adjusted, unadjusted, gap fill, etc.) -Other (including ASC facility fees, radiology and outpatient limits and non-payment because of denial) -Lab Fee Schedule

Information		Description
26.	ESRD Indicator	Coded to identify beneficiary. -ESRD Beneficiary -Not ESRD Beneficiary
27.	Beneficiary Sex Code	Coded as follows: -Male -Female -Unknown
28.	Locality	This 2-digit code is used to identify the pricing locality.

Exhibit B

Person Summary File

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	State Code	SSA geographic code obtained from Master Record indicating State of beneficiary's residence.
3.	County code	SSA code obtained from Master Record indicating county of beneficiary's residence.
4.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
5.	Date of Birth	Beneficiary's date of birth.
6.	Date of Death	Beneficiary's date of death.
7.	Race	-White -Non-White -Unknown
8.	Sex	-Male -Female
9.	Age	Age at last birthday as of 07/01/YY if alive at end of year. For aged age 64, consider as age 65. For disabled age 65, consider as age 64. For persons who died, use age as of date of death.

	Information	Description
10.	Patient Status	-Discharged (alive) -Died -Still patient
11.	Number of Inpatient Stays	

Reimbursement Amounts (Dollars and Cents)

12.	Inpatient Hospital	
13.	Skilled Nursing Facility	
14.	HHA Part A	
15.	Physician and Other Medical Services	
16.	Outpatient	
17.	HHA Part B	
18.	Total Part A	
19.	Total Part B	
20.	Total Part A and/or Part B	
21.	Part A and Part B	
22.	Part A only	
23.	Part B only	

Provider Summary Public Use File

	Information	Description
1.	Provider Number	Six position number identifies a provider. First two positions are the State code. Positions 3 and 4 identify a specific facility. Positions 5 and 6 are numeric except for emergency and Federal hospitals which are coded E and F respectively in the 6th position.
2.	Type of Facility	-Hospital -Skilled Nursing Facility -Christian Science Sanatorium -Home Health Agency -Other
3.	Bill Through Date	Ending date or discharge date shown on bill (YR-MO).
4.	Discharge Data	Data below are derived from Inpatient Hospital or SNF covered and non-covered bills.
	a. Aged	Data for beneficiaries who are aged: -Number of Discharges - alive -Number of Days of cae - alive -Number of Discharges - dead -Number of Days of care - dead
5.	Bill Type Data	Data below are derived from specific bill types: e.g., inpatient, SNF, HHA, etc.
	a. Bill Form code	Type of bill (see above)
	b. Part Code	Part A, Part B or HHA
	c. Total charges or Visit charges	Total charges for all services or for HHA visits
	d. Non-covered charges	Non-covered charges for all accommodations and charges
	e. Total Reimbursement	Total amount paid to or on behalf of the beneficiary

	Information	Description
6.	Monthly Total Days	"From date" to "through date" for inpatient and SNF facilities
7.	Transferred Indicator	Part of a short stay hospital not covered by PPS: blank - provider number not changed S - Psychiatric Unit T - Rehabilitation Unit U - Swing Bed Hospital V - Alcohol/Drug Unit
8.	PPS Indicator	1 - PPS 0 or blank - Non PPS

Exhibit D

Outpatient Bill Skeleton Record - 5% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Date of Birth	Year and Julian date of beneficiary's birth.
3.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
4.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
5.	State Code	SSA geographic code obtained from Master Record indicating State of beneficiary's residence.
6.	County Code	SSA geographic code obtained from Master Record indicating county of residence.
7.	ZIP Code of Residence	Actual
8.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim.
10.	Type of Service	-Inpatient -Outpatient -Other
11.	Diagnosis Code (Field is repeated five times)	Diagnostic code assigned from ICD-9-CM, Volumes I and II.

	Information	Description
12.	Surgical Procedure Code (Field is repeated three times)	Code assigned from ICD-9-CM, Volume III.
13.	Number of Clinic Visits	Actual Number.
14.	Number of Emergency Room Visits	Actual Number.
15.	Covered Charges	Covered charges for each service: -Clinic Visits -Emergency Room -Laboratory -Radiology -Pharmacy -Blood -Ambulance -Physical Therapy -ESRD -Other
16.	Total Covered Charges	Total covered charges for above services.
17.	Date of Last Service	Year and Julian date of last service.
18.	Amount Reimbursed	An interim payment made to the institution. Final reimbursement is made on a cost basis based on the cost report each institution is required to prepare at the end of their fiscal year.
19.	Surgery Indicator	Indicates if surgery was performed.
20.	Unibill Indicator	Indicates if Unibill or Patbill.
21.	Number of Revenue Center Codes	Number of Unibill Revenue Center Codes for services.

Exhibit D

Information	Description
22. Revenue Center Information	
a. Codes	Identifies specific revenue center.
b. Units	Number of times the revenue center was accessed.
c. Charges	Charges for each revenue center code.
23. Bill - Value - 1	Based on Query code -1 Credit Adjustment +1 Debit Adjustment

Home Health Agency Skeleton Record - 40% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Date of Birth	Year and Julian date of beneficiary's birth.
3.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
4.	Race	Race code from HI Master Record: -White -Black -Unknown
5.	State Code	SSA Geographic code obtained from HI Master Record indicating State of beneficiary's residence.
6.	County Code	SSA Geographic code obtained from HI Master Record indicating county of beneficiary's residence.
7.	ZIP Code of Residence	Actual
8.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim.
10.	Record Identification Code	-Part A -Part B
11.	Diagnostic Code	Code assigned from ICD-9-CM, Volumes I and II.
12.	Number of Diagnoses	

Exhibit E

	Information	Description
13.	Period From Date	Year and Julian from date of billing period.
14.	Period Through Date	Year and Julian through date of billing period.
15.	Status Code	-Discharged alive -Died -Still Receiving Services
16.	Visits and Charges A. Skilled Nursing Care B. Physical Therapy C. Speech Therapy D. Occupational Therapy E. Medical Social Services F. Home Health Aide G. Other Visits (1) Other Visits (2)	For each category: -Number of Visits -Dollars and Cents
17.	Total Visits	Total visits for all services.
18.	Total Visit Charges	Total charges for HHA visits.
19.	Other Charges	Total other charges.
20.	Total Charges	Total charges including other charges.
21.	Reimbursement Amount	An interim payment made to the institution. Final reimbursement is made on a cost basis based on the cost report each institution is required to prepare at the end of their fiscal year.
22.	Query Code	
23.	Unibill Indicator	Indicates whether Unibill or Patbill.
24.	Original BIC	Beneficiary Identification code as submitted on bill.

IX. Continuous Medicare History Sample File

Introduction

The Health Insurance System provides for processing and maintenance of all utilization health insurance bills, payment records, and enrollment records. As a by-product of this system, individual HCFA statistical files are obtained to provide data bases for all types of information on the health insurance program. Until the implementation of the Continuous Medicare History Sample (CMHS), all requests for person data over a time period of more than a single year had to be processed by combining various individual files. A more efficient method of obtaining hospital and medical insurance data is to create a sample file consisting of selected fields from the various Medicare bill files on an ongoing scheduled basis. Such a file permits more in-depth studies of utilization patterns over extended time periods.

The CMHS file is intended to provide more efficient access to person data on a longitudinal basis. This file, being a combined file and having annual updates, has eliminated the problem of having to refer to old files with old formats. Information for all years (representing services after 1973) are consistent and fully documented and contained in this one file.

Preparation of CMHS

The CMHS file is prepared on a 5 percent sample person basis for years 1974 and later and provides a combined record of all Medicare activity for each year. Selection of beneficiaries to be included in this file is based on the ever-enrolled (1974 and later) concept. Thus, beneficiaries enrolled in the Medicare program after 1973, regardless of utilization activity, are represented in this file. Selected personal characteristics are obtained from both the active and inactive HISKEW files. Utilization data for each year are selected from inpatient hospital, SNF, home health agency, and outpatient bills that are processed by Medicare intermediaries, and physicians. Service information is obtained from payment records that are processed by Medicare carriers.

Each portion obtained is then combined to form one record for each Medicare beneficiary within the sample on an ongoing basis. Once a beneficiary is included in the CMHS sample that person remains on the file regardless of activity or death. This provides the flexibility for ready access of person data needed to follow utilization patterns of each sample beneficiary.

The initial selection of beneficiaries included in this sample file was based on records obtained from the active and inactive HI Master Enrollment Record as of the update closest to April 1, 1975, with the following characteristics:

1. Primary and/or cross-reference HI claim number in the 5 percent sample.

2. Current entitlement to hospital insurance benefits (Part A) and/or supplementary medical insurance benefits (Part B) was before January 1, 1975, without current termination before January 1, 1974, i.e., anyone ever enrolled in 1974.

Subsequent updates of additional beneficiaries will continue to be based on entitlement after 1973 and will be obtained annually from the updated Master Enrollment File. In addition to newly entitled beneficiaries, those previously included are reselected from

the enrollment file from subsequent years for use in a current update. This provides the CMHS file with current demographic characteristics. An annual segment is appended to the Master Record portion of all active beneficiaries and provides the means for noting changes in benefit status, residency, and type of enrollment. The status and coverage characteristics are based as of July 1 of the reference year.

All sample utilization records (bills and payment records) included in the initial preparation of the CMHS were selected from records processed through June 1975 with services in 1974.

Subsequent annual updates to the CMHS included those initial debit utilization records with service dates after December 31, 1973, processed since the prior years' file through the June update of the current year. Thus, when accreting for 1980 activity, only sample records with service dates of 1974-1980 and processed through June 1981 are used. The types of utilization records used to obtain information are as follows:

1. MEDPAR Stay Records

   a. Inpatient hospital stay records representing complete stays are summarized by year of discharge. The discharge date, status and diagnostic related group (DRG) of the last short-stay hospitalization is retained with the summary information on short-stay hospital utilization.

   b. Skilled nursing facility (SNF) stay records representing complete and incomplete stays are summarized by year of admission. The incomplete SNF stays are replaced in subsequent updates when a complete record with a discharge date has been processed.

2. Home Health Agency (HHA) Bill Skeleton Records.
   These records contain information on visits and services delivered by HHA providers and are summarized by year based on through-date of service.

3. Outpatient Hospital Bill Records
   These records represent bills for visits to and services provided in hospital emergency rooms and outpatient clinics. The utilization is summarized by year of the last service date for each type of service.

4. Part B Payment Records
   These records represent payments for services delivered by non-institutional providers such as physicians, suppliers, laboratories, etc.. Several types of utilization determined by specialty code and place of service are summarized by year using the last expense date.

5. Group Health Plan (GHP) Master Enrollment
   The GHP master file is used to identify CMHS beneficiaries with any GHP enrollment.

Contents of the CMHS Record

The complete CMHS record varies in size, based on whether Medicare utilization is present or not, type of service utilized by the beneficiary and the number of years involved. Approximately 1.3 million records were initially established in 1974 and subsequent year updates have added an estimated 100,000 records annually. The file is maintained in beneficiary sequence and contains the following sections:

1. Fixed Portion
   This portion is present for every beneficiary on the CMHS and is comprised of the following groups:

   a. enrollment group: contains personal characteristics of the beneficiary such as date of birth, sex, race, entitlement dates, date of death and current update information.

   b. years present: contains an indicator of eligibility for each year maintained on the CMHS.

   c. trailer counts: contains the number of occurrances of each section of variable data.

2. Annual Data: Present for every year of eligibility and contains demographic data, indicator of utilization, total reimbursement, and yearly indicators.

3. Demographic Data: Provides the means for noting change in benefit status, residency, and type of enrollment.

4. HHA Trailer: Contains utilization (visits, charges, reimbursement) for an estimated 75,000 beneficiaries per year.

5. Outpatient Trailer: Contains utilization (bills, charges, reimbursement) for an estimated 500,000 beneficiaries per year,

6. Payment Trailer: Contains utilization (records, reasonable charges, reimbursement) for an estimated million beneficiaries per year.

7. Inpatient Trailer: Contains utilization (stays, days charges, reimbursement) for an estimated 350,000 beneficiaries per year.

8. SNF Trailer: Contains utilization (stays, days, charges, reimbursement) for an estimated 14,000 beneficiaries per year.

9. GHP Trailer: This section provides information (plan-number, status, dates) for each GHP membership period.

Note: Exhibit A details the record description of each field possible for a CMHS beneficiary. Due to various process changes certain items may only be available since the system redesign (effective with 1982 data).

Exhibit A

Fixed Portion

	Information	Description
1.	Record Size	-Length of Record
2.	Record Type	-Accreted in or after 1982 -No eligible update after 1981 -Updated after 1981
3.	HCFA Claim Number	-HCFA Claim Number
4.	Beneficiary Identification Code (BIC)	-Equated BIC
5.	First Update	-YY-First Year -DDD
6.	Last Update	-YY-Last Year -DDD
7.	Last Stay Data	-Information from last short-stay hospitalization Note: Not available if no eligible update after 1981.
	a. Discharge Date b. DRG c. Discharge Status	-YYDDD -DRG Code -Alive -Dead -Still a patient
8.	Date of Birth	-YYDDD
9.	Sex	-Unknown -Male -Female
10.	Race	-Unknown -White -Black -Other
11.	Latest Part A Entitlement	-YYDDD
12.	Latest Part A Termination	-YYDDD
13.	Prior Part A Entitlement	-YYDDD

Fixed Portion

	Information	Description
14.	Prior Part A Termination	-YYDDD
15.	Reason For Latest Part A Termination	-No Termination -Death -Non-Payment of Premium -Voluntary Withdrawal -Entitled Under Another Number -Cessation of Disability -Other
16.	Latest Part B Entitlement	-YYDDD
17.	Latest Part B Termination	-YYDDD
18.	Prior Part B Entitlement	-YYDDD
19.	Prior Part B Termination	-YYDDD
20.	Reason For Latest Part B Termination	-Same as Part A
21.	Date of Death	-YYDDD
22.	Original Reason for Entitlement (OREC)	-Original Reason for Entitlement -OASI -DIB -Renal -DIB & Renal
23.	Original BIC	-Original BIC Code
24.	Lifetime Reserve Days	-Lifetime Reserve Days Remaining
25.	Lifetime Psychiatric Days	-Lifetime Psychiatric Days Remaining
26.	Years Present	-Each field contains 1 of 15 possible years of eligibility (1974-1989) -Y Eligible for year -N Not eligible for year

Exhibit A

Trailer Counts

1.	Number of Annual Trailers	-Number of annual trailers
2.	Number of Demographic Trailers	-Number of unique demographic trailers
3.	Number of Home Health Agency (HHA) Trailers	-Number of HHA Trailers
4.	Number of Outpatient (OP) Trailers	-Number of OP Trailers
5.	Number of Payment Record Trailers	-Number of Payment Record Trailers
6.	Number of Inpatient Trailers	-Number of Inpatient Trailers
7.	Number of Skilled Nursing Facility (SNF) Trailers	-Number of SNF Trailers
8.	Number of Group Health Plan (GHP) Periods	-Number of GHP Membership Periods Note: Does not represent years for GHP

Annual Data

	Information	Description
1.	Utilization Key	-Value Space
2.	Utilization Year	-YY (E.G. 74)
3.	Demographic Trailer Location	-Actual location of demographic trailer for the utilization year
4.	Utilization Indicator	-Y - Trailer present for utilization year -N - Trailer not present for utilization year
	a. Home Health Agency Indicator	- Y or N
	b. Outpatient Indicator	- Y or N
	c. Payment Record Indicator	- Y or N
	d. Inpatient Indicator	- Y or N
	e. Skilled Nursing Facility Indicator	- Y or N
5.	Part A Reimbursement	-Total Part A Reimbursement
6.	Part B Reimbursement	-Total Part B Reimbursement
7.	Part B Medical Expense	-Total Part B Medical Expenses from Part B query
8.	GHP-Indicator	Group Health Plan Enrollment -None -HMO -HCPPP -HMO & HCPPP -GPPP -HMO & GPPP -GPPP & HCPPP -HMO & HCPPP & GPPP
9.	Part A Third Party	-No Third Party Involvement -State Buyin -Reserved -Civil Service -Third Party
10.	Part B Third Party	-Same as field 9

Exhibit A

Demographic Data

	Information	Description
1.	Type	-Value '*'
2.	Year	-First year of unique data
3.	Current Reason for Entitlement Code	Current reason for entitlement -OASI -DIB -Renal -DIB & Renal
4.	Medicare Coverage Code	-Medicare Coverage Code -None -Part A Only -Part B Only -Part A & Part B
5.	Medicare Status Code	Medicare Status Code -Aged without ESRD -Aged with ESRD -DIB without ESRD -DIB With ESRD -ESRD Only
6.	End Stage Renal Disease Indicator	Notice of ESRD -No ESRD -ESRD
7.	State of Residence	-SSA State Code
8.	County of Residence	-SSA County Code
9.	ZIP Code of Residence	-ZIP code

Home Health Agency Trailer

	Information	Description
1.	Type	-Value 'A'
2.	Year	-Reference Year -Obtained from 'Through Date'
3.	Part A Totals	
	a. Visits	-Number of Part A Visits
	b. Charges	-Total Part A charges
	c. Other Charges	-Total Part A other charges
	d. Reimbursement	-Total Part A Reimbursement
4.	Part B Totals	
	a. Visits	-Number of Part B Visits
	b. Charges	-Total Part B Charges
	c. Other Charges	-Total Part B Other Charges
	d. Reimbursement	-Total Part B Reimbursement

Outpatient Trailer

	Information	Description
1.	Type	-Value 'B'
2.	Year	-Reference Year Obtained from 'Last Service Date'
3.	Services	-Type of Service Outpatient
	a. Bills	-Number of Bills
	b. Covered Charges	-Dollars
	c. Reimbursment	-Dollars
4.	Outpatient Inpatient Services	-Type of Service Inpatient
	a. Bills	-Number of Bills
	b. Covered Charges	-Dollars
	c. Reimbursement	-Dollars
5.	Outpatient Other Services	-Type of Service Other
	a. Bills	-Number of Bills
	b. Covered Charges	-Dollars
	c. Reimbusement	-Dollars

Payment Record Trailer

	Information	Description
1.	Type	-Value 'C'
2.	Year	-Reference Year Obtained from 'Last Expense' Field
3.	All Services	-Total Hospital and Non-Hospital
	a. All Records	-Total Records
	b. All Reasonable Charges	-Dollars
	c. All Reimbursements	-Dollars
4.	Physician Services	-Total Physicians Services
	a. Physician Records	-Total Physicians Records
	b. Physician Reasonable Charges	-Dollars
	c. Physician Reimbursement	-Dollars
5.	Surgical Services	-Total Surgical Services
	a. Surgical Records	-Total Surgical Records
	b. Surgical Reasonable Charges	-Dollars
	c. Surgical Reimbursement	-Dollars
6.	Supplier Services	-Total Supplier Services
	a. Supplier Records	-Total Supplier Records
	b. Supplier Reasonable Charges	-Dollars
	c. Supplier Reimbursement	-Dollars
7.	Hospital Services	-Total Hospital Services
	a. Hospital Records	-Total Hospital Records
	b. Hospital Reasonable Charges	-Dollars
	c. Hospital Reimbursement	-Dollars
8.	Psychiatric Charges	-Total Psychiatric Charges
9.	Unassigned Totals	-Total unassigned Totals
	a. Unassigned Records	-Total unassigned Records
	b. Unassigned Reimbursement	-Dollars

Exhibit A

Inpatient Trailer

	Information	Description
1.	Type	-Value 'D'
2.	Year	-Reference year obtained from 'Discharge Date' field
3.	Totals	-Inpatient Totals
	a. Stays	-Number of Stays
	b. Covered Days	-Covered Days
	c. Length of Stay	-Length of Stay
	d. Charges	-Dollars
	e. Covered Charges	-Dollars
	f. Reimbursement	-Dollars
	g. Lifetime Reserve Days	-Lifetime Reserve Days Used
	h. Coinsurance	-Coinsurance Days Used
4.	Intensive Care Unit Days	-Intensive Care Unit/ Coronary Care Unit Days
5.	Intensive Care Unit Charges	-Intensive Care Unit/ Coronary Care Unit Charges
6.	Departmental Charges	-Departmental Charges
7.	Short Stay Data	
	a. Stays	-Number of Stays
	b. Covered-Days	-Covered Days
	c. Length of Stay	-Length of Stay
	d. Charges	-Dollars
	e. Covered Charges	-Dollars
	f. Reimbursement	-Dollars
	g. Lifetime Reserve Days	-Lifetime Reserve Days Used
	h. Coinsurance Days	-Coinsurance Days Used

Skilled Nursing Facility Trailer

Information	Description
1. Type	-Value 'E'
2. Year	-Reference year Obtained from 'Admission Date' field
3. Totals	
a. Stays	-Number of Stays
b. Covered Days	-Covered Days
c. Length of Stay	-Length of Stay
d. Charges	-Dollars
e. Covered Charges	-Dollars
f. Coinsurance Amount	-Dollars
g. Reimbursement	-Dollars
h. Coinsurance Days	-Coinsurance Days Used

Exhibit A

Group Health Plan Trailer 1/

Information	Description
1. Plan Number	-ID Number of Group Health Plan (GHP) from GHP Master
2. Status Code	-Current membership status -Active -Deceased -GHP Delete -SSA Termination
3. Entitlement Type	-Combination of Medicare Entitlement code and GHP restriction. Present for HMO/HCPPP Only
4. Part B Data	
a. Part B Accretion	-YYDDD effective date of Part B GHP Membership
b. Part B Deletion	YYDDD Effective date of part B GHP Deletion
5. Part A Data	
a. Part A Accretion	-YYDDD Effective date of Part A GHP membership
b. Part A Deletion	YYDDD Effective Date of Part A GHP Deletion

1/ Note: These are not yearly trailers. There is a trailer for each membership period.

X. End Stage Renal Disease Program Management and Medical Information System

Introduction

Persons with End Stage Renal Disease (ESRD) became eligible for Medicare benefits on July 1, 1973. The ESRD Program Management and Medical Information System (PMMIS) captures patient-specific data on Medicare ESRD beneficiaries. The system also captures certification and other types of information on providers approved by Medicare to furnish kidney dialysis and transplant services, and contains aggregate patient population counts.

Source Documents and Input

Documents containing patient-specific information are originated at the social security office and renal provider levels. In addition, inpatient and outpatient billing records are passed through the PMMIS and certain data are extracted and made a part of the record. Aggregate patient population data are received annually from renal providers; and provider certification, Minimum Utilization Rates (MUR), and other provider characteristics come from the regional offices and/or intermediaries.

The patient-specific forms are batched in Baltimore and sent to Salinas, CA, for keying. They are transmitted back for introduction into the Health Insurance System, which routes them along with all bills for ESRD patients to the PMMIS.

Aggregate patient population data are received in hard copy form from the renal providers; these data are keyed in Salinas and made part of the Facility Survey File. Certification and other provider characteristics data are accreted on-line into the Renal Provider File, which interfaces with the Medicare Provider Master File.

Update Mechanism and Quality Control Measures

The patient-specific information is updated monthly. Master identification records are updated from identification records from the Health Insurance System. Patient-specific records from the keyed forms are edited and posted if valid. Records with errors are routed to an on-line file for correction. Inpatient and outpatient billing information is posted to the appropriate beneficiary records. At the conclusion of this batch updating, an M204 on-line data base is created containing much of the patient-specific data from the batch files.

Provider certification and characteristics data are updated as received; aggregate patient population data are updated annually on magnetic tapes.

Hard copy data are reviewed and verified prior to keying. Data, once keyed, are run through consistency and logic edits. Rejected records appear on error listings and are corrected manually and rerun through the system.

Dependent Systems and Outputs

No other systems are dependent on the PMMIS.

Recurring tabulations, analyses, and reports are prepared on monthly and annual basis.

Special reports are prepared and analyses performed to respond to requests from other components of HCFA and DHHS, the Congress, the renal professional community, the media, and various research organizations.

Exhibit A describes the patient-specific portion of the PMMIS.

Exhibit B describes the magnetic tape containing provider characteristics and aggregate patient population data.

ESRD PMMIS Transplant--Pre-1983 Format

Information	Description
ESRD PMMIS TRANSPLANT INCIDENT	Source: HCFA-600-1 Transplant record, HCFA-1453 Inpatient record. Restricted use data file.
1. Record Identification Code	Identifies the record format being processed.
2. Social Security Number and Beneficiary Identification Code	PMMIS Internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3. Transplant Record Post Date	Date transplant posted.
4. Record Format Indicator	-Old format: 75 positions -HCFA-2745 format: 370 positions
5. Incident Counter	Ascending chronological sequence number distinguishing recurring records of this type.
6. Transplant Provider	Provider reporting transplant Source: HCFA-600-1, HCFA-1453.
7. Date of Transplant	Date of reported transplant.
Donor Data	Following data pertain to organ donor.
8. Transplant Donor Type	Source: HCFA-600-1 -Monozygotic Twin -Dizygotic Twin -Sibling -Genetic Parent -Child -Cadaver -Other -Living related
9. Age at Transplant	
10. Race Code	Source: HCFA-600-1, Item 13. Possible values -White -Black -Oriental -American Indian -Other -Unknown

11. Blood Type	Donor blood type.
Recipient Data	Following data pertain to organ recipient.
12. Race Code	Source: HCFA-600-1, Item 13. Possible values -White -Black -Oriental -American Indian -Other -Unknown
13. Sex Code	Code which identifies the sex of the beneficiary (from master file). -Unknown -Male -Female
14. Blood Type	Recipient blood type.
15. Cross-Match Results	Source: HCFA-600-1, Item 15. -Unspecified -Not performed -Positive -Negative -Equivocal
16. Lymphocyte Culture	Source: HCFA-600-1, Item 16. -Unspecified -Not performed -Positive -Negative -Equivocal
17. Date of Culture	Julian date. Source: HCFA-600-1, Item 16.
18. Tissue Type Donor	Source: HCFA-600-1, Item 18. Codes indicating tissue type. -A-AW1 Series -A-AW2 Series -B-BW1 Series -B-BW2 Series -CW1 Series -CW2 Series

	Information	Description
19.	Tissue Type Recipient	Source: HCFA-600-1, Item 17. Codes indicating tissue type. -A-AW1 Series -A-AW2 Series -B-BW1 Series -B-BW2 Series -CW1 Series -CW2 Series
20.	Days in Inpatient Hospital	Computed from HCFA-1453 discharge record.
21.	Type of Inpatient Dialysis	-Hemodialysis -Peritoneal -Both
22.	Number of Dialysis Sessions	
23.	Hospital Indicator	For future use.
24.	Recycle Indicator	For internal use.
25.	Cross-Match Indicator	Indicates a cross-match was made. -No -Yes
26.	Transplant Status	-Source: HCFA-1483, HCFA-1453, HCFA-600-1, HCFA-2746 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
27.	Inpatient Indicator	-HCFA-600-1 only, no stay record or AMCS record received. -HCFA-600-1, and stay record posted. -HCFA-600-1, stay record and AMCS record posted -No HCFA-600-1, stay record and AMCS record only

Exhibit A

ESRD PMMIS Identification Record

	Information	Description
1.	Record Identification Code	Identifies the record being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Cross-Reference Claim Number and Beneficiary Identification Code	Previous health insurance claim number or beneficiary's own social security number. Beneficiary identification code "**" indicates the beneficiary's own social security number. Identifies relationship to SSN.
4.	Type of PMMIS Transaction	Most recent transaction to PMMIS. -Chronic Renal Disease Reimbursement Utilization Record (CRD RUS) -HI Master Identification Record -ESRD Transplant Record -ESRD Patient History Record/Medical Evidence Record -ESRD Dialysis Record -ESRD Hospital Record -Noncovered Bill Record -ESRD Death Notice Record -Master Record Cross-Reference Maintenance Record -Master Record Disabled Cross-Referencing -1978 Census Record
5.	Date PMMIS Transaction	Date of most recent transaction to PMMIS.
6.	HIM Identification Post Date	Date HIM Master record posted to PMMIS.
7.	Date of Accretion	Date record was accreted to the file.
8.	Date of Birth	Julian date of beneficiary's birth.
9.	Date of Death	Julian date of beneficiary's death.

Information	Description
10. Sex Code	Code which identifies the sex of the beneficiary (from Master File). -Unknown -Male -Female
11. Race Code	Beneficiary race (From Master File) -Unknown -White -Black -Other
12. Ledger Account File Code	Benefit payment status/reason for status.
Current Part A Dates	Dates refer to most recent entitlement to Medicare Part A (HI) benefits. Note: Entitlement to Part A (HI) and not Part B (SMI) is possible.
13. Date of Entitlement	Julian date entitlement began.
14. Date of Termination	Julian date entitlement terminated.
Current Part B Dates	Dates refer to most recent entitlement to Medicare Part B (SMI) benefits.
15. Date of Entitlement	Julian date entitlement began.
16. Date of Termination	Julian date entitlement terminated.
Prior Part A Dates	
17. Date of Entitlement	Julian date entitlement began. Zeroes indicate no entitlement.
18. Date of Termination	Julian date entitlement terminated.
Prior Part B Dates	
19. Date of Entitlement	Julian date entitlement began.
20. Date of Termination	Julian date entitlement terminated.

Exhibit A

	Information	Description
21.	HIM Source Date of Death	-All off -Master Beneficiary Record (MBR) -Medical bill -Beneficiary deceased, Source: MBR/Medical bill or clerical
22.	Early Entitlement Indicator	For internal use only. -No early entitlement -Early entitlement
23.	Original Reason for Entitlement	Indicates reason for beneficiary's original entitlement to Medicare benefits. -Old Age and Survivors Insurance (OASI) -Disability Insurance Benefits (DIB) -Renal -DIB and Renal
24.	Current Reason for Entitlement	Indicates reason for beneficiary's current entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
25.	End Stage Renal Disease (ESRD) Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -National Institutes of Health (NIH) -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI, and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH, and Clerical
	Beneficiary Name	
26.	Beneficiary Surname	May be truncated.

	Information	Description
27.	Given Name	Given name. May be truncated.
28.	Middle Initial	Beneficiary's middle initial.
	Beneficiary Address Data	
29.	State Code	SSA Standard State Code.
30.	County Code	SSA Standard Codes.
31.	ZIP Code	May contain spaces or invalid codes.
32.	Network of Residence	Determined from State and County Code.
33.	HCFA Region	Determined from State Code.
	Beneficiary Address Prior Year	
34.	State Code	SSA Standard State Code.
35.	County Code	SSA Standard Codes.
	Beneficiary Address 2 Years Prior	
36.	State Code	SSA Standard State Code.
37.	County Code	SSA Standard Codes.
38.	Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81) or HCFA-2745 (1/82) received. -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
39.	Age ESRD PMMIS	Current age computed as of July 1 or as of July 1 of year of death.
40.	First Date of ESRD Service	Earliest date of dialysis or transplant. Source: HCFA-1450, HCFA-1453, HCFA-1483, HCFA-2728, HCFA-2745

	Information	Description
41.	Type of First ESRD Service	-Dialysis -Transplant
42.	Date Claim Number Cross-Referred	Date HI cross-reference transaction is posted to PMMIS.
43.	Investigation Code	For future use.
44.	Source of Primary Provider Code	-Transplant provider, transplant functioning -Transplant provider, beneficiary died within 90 days of transplant -Dialysis provider, billed CAPD services in latest quarter -Dialysis provider, billed 21 most recent sessions -Dialysis provider, billed most sessions in latest 2 quarters -Transplant provider, HCFA-2728 -Dialysis provider, HCFA-2728
45.	Primary Provider	
46.	Year of Part B Expense	
47.	Queried Part B Expenses	Linked to year of Part B expense.
48.	M204 Database Indicator	For future use.
49.	First Date of Dialysis	Earliest legitimate date.
50.	Source First Date of Dialysis	-Earliest HCFA-2728 -Earliest billed dialysis sessions, HCFA-1483, HCFA-2743 -DOEA (OREC = 2 or 3, EE1 = 1) -DOEA - 3 months (OREC = 2 or 3)
51.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -DIB without ESRD -DIB with ESRD -ESRD only
52.	Current Dialysis Type	Most current reported type of dialysis. -Hemodialysis -Peritoneal -Both -CAPD -CCPD

	Information	Description
53.	Death Notification Provider	Provider submitting ESRD Death Notification, HCFA-2746
54.	Place of Death	Source: HCFA-2746, HCFA-1453, HCFA-1450 -Hospital -Dialysis Facility -Home -Other -Unreported
55.	Autopsy Indicator	Source: HCFA-2746 -Yes -No -Unreported
56.	Primary Cause of Death	Source: HCFA-2746 -Pericarditis (Including cardiac tamponade) -Myocardial infarction, acute -Cardiac (Other than pericarditis or myocardial infarction, acute) -Cerebrovascular (Including spontaneous subdural hematoma) -Embolism, air -Embolism, pulmonary -GI hemorrhage -Vascular access -Hemorrhage -Pulmonary infection -Septicemia -Viral hepatitis -Infection -Hyperkalemia -Pancreatitis -Malignancy -Withdrawal from dialysis -Suicide -Accidental death, treatment related -Accidental death, not treatment related -Unknown cause -Other (specify in remarks)
57.	Secondary Cause of Death	See causes above.
58.	Batch Number HCFA-2746	Internal use (1983 to current).

Exhibit A

	Information	Description
59.	Transplant Status	Source: HCFA-1483, HCFA-1453, HCFA-1450, HCFA-2745, HCFA-2746 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
60.	Death Indicator	-HIM only -HCFA-2746 only -Both -No death indicator
61.	Malignancy Indicator	Malignancy indicated Source: HCFA-2742 (expired 10/81), HCFA-2746
62.	Number of Medical Evidence Records	Number of RIC "B" records on the file.
63.	Number of Transplant Records	Number of RIC "C" records on the file.
64.	Number of Dialysis Records	Number of RIC "G" records on the file.
65.	Number of Inpatient Stay Records	Number of RIC "E" records on the file.
66.	Current Treatment Setting	Most current (date of service) reported treatment setting. -Staff -Self-Care -Self-Care Training -Home -Inpatient -Transplant
	Most Current Data	
67.	Dialysis Provider	Dialysis provider reporting medical evidence. Source: HCFA-2728, Item 18; HCFA-2742, Item 9.
68.	Date of Dialysis	"Through date" of dialysis claim, first date of dialysis from HCFA-2728 if no billed date of dialysis. Source: HCFA-1483, HCFA-2728

	Information	Description
69.	Transplant Provider	Provider reporting transplant. Source: HCFA-600-1, HCFA-2745, HCFA-1453, HCFA-1450
70.	Date of Transplant	Date of reported transplant.
71.	Transplant Donor Type	Source: HCFA-600-1, HCFA-1453, HCFA-1450 -Monozygotic Twin -Dizygotic Twin -Sibling -Genetic Parent -Child -Cadaver -Other -Living Related -Unspecified (HCFA-1453)
72.	Inpatient Stay Date	Date of admission of reported inpatient stay. Source: HCFA-1453, HCFA-1450
73.	Number of HMO Periods	Count of number of HMO periods.
74.	HMO Number	Plan number for HMO.
75.	HMO Option Code	-HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills. -HMO to process all Part A and Part B bills.
76.	Current HMO Effective Date	Effective date of HMO period.
77.	Current HMO Termination Date	Termination date of HMO period.
78.	Prior HMO Number	Plan number of HMO.
79.	Prior HMO Option Code	-HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills. -HMO to process all Part A and Part B bills.

	Information	Description
80.	Prior HMO Effective Date	Effective date of prior HMO period.
81.	Prior HMO Termination Date	Termination date of prior HMO period.
82.	HMO Indicator	-Never in HMO. -Deceased beneficiary had HMO involvement. -Beneficiary was enrolled in HMO in the past. -Beneficiary is currently enrolled in an HMO.
83.	Resident Network	New Network designation.
84.	Source Date Transplant Failure	Earliest of: -Date of subsequent transplant -Midpoint of first quarter after 22 sessions occurred. -Date of nephrectomy -Date of death (death occurred within 90 days of transplant) -Date of death (death occurred during transplant hospital stay) -Date of death (death notification form indicated transplant failed) -Date CAPD or CCPD began. -Date returned to dialysis per 2728.
85.	Date of Transplant Failure	Julian date.
86.	Transplant Death	-Death occurred within 90 days of transplant or within the same hospital stay. -Death occurred more than 90 days after transplant -No date of death
87.	Beneficiary Identification Code	Identifies beneficiary's relationship to SSN.

	Information	Description
88.	Possible Renal Activity Indicator	Errored records received. -None -HCFA-2728 -HCFA-2745 -HCFA-2728, HCFA-2745 -HCFA-2746 -HCFA-2728, HCFA-2746 -HCFA-2728, HCFA-2745 -HCFA-2728, HCFA-2745, HCFA-2746 -HCFA-1483, HCFA-1450 -HCFA-1453, HCFA-1450, other
89.	Date Most Current Errored Record	Links to Possible Renal Activity Indicator Field.
90.	Recycle Indicator	For internal use.
91.	Control Count	For internal use.
92.	Delete Count	For internal use.
93.	Date Last Update From HIM	Date most current HIM identification record posted.
94.	Current Primary Payer Code	Primary payer code on latest out-patient or in-patient bill posted.
95.	MSP (Medicare Secondary Payer) Ever	Secondary payer codes. 'B' (ESRD) has priority.
96.	Renal Indicator	-Clerically Set -Not set clerically -Data code 38 in HIM set using HCFA-1363.

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ESRD Medical Evidence Record

	Information	Description
	ESRD MEDICAL EVIDENCE RECORD	A record can occur for each period of ESRD entitlement. Source: HCFA-2728 (10/81 to present) HCFA-2742 (1/77 to 9/81)
1.	Record Identification Code	Identifies the record format being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficary identification code.
3.	Medical Evidence Post Date	Date medical evidence record was posted to the PMMIS.
4.	Primary Disease Causing ESRD	Code from International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
5.	Dialysis Provider	Dialysis provider reporting medical evidence. Source HCFA-2728, Item 18; HCFA-2742, Item 9.
6.	First Type of Regular Dialysis	-Hemodialysis -Peritoneal -Both -Continuous Ambulatory Peritoneal Dialysis (CAPD) -Continuous Cycling Peritoneal Dialysis (CCPD)
7.	Date Regular Dialysis Began	
8.	Transplant Provider	Provider reporting transplant.
9.	Date of Transplant	Julian date of reported transplant.
10.	Transplant Status	-Functioning -Rejected
11.	Date Returned to Dialysis	

Exhibit A

	Information	Description
12.	Self-Care Training Provider	Medicare-approved ESRD training provider.
13.	Date Training Began	
14.	Type of Self-Care Training	-Hemodialysis -Peritoneal -CAPD -CCPD
15.	Date of Medical Certification	
16.	Source of Medical Evidence	-HCFA-2728 -HCFA-2742
17.	Processing Batch Number	For internal use.

ESRD PMMIS Transplant -- Current Format

	Information	Description
1.	Record Identification Code	Identifies the record format being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Transplant Record Post Date	Date transplant record posted to PMMIS.
4.	Record Format Indicator	-Old format: 75 positions -HCFA-2745 format: 370 positions
5.	Incident Counter	Ascending chronological sequence number distinguishing recurring records of this type.
6.	Transplant Provider	Provider reporting transplant. Source: HCFA-2745, HCFA-1453, HCFA-1450
7.	Date of Transplant	Date of reported transplant.
8.	Transplant Donor Type	-Monozygotic twin -Dizygotic twin -Sibling -Genetic parent -Child -Cadaver -Other -Living Related -Unspecified
9.	Disposition Code	Original reply code.
10.	Batch and Sequence	Assigned by clerical unit receiving record. This number represents- 4-position Date (YDDD) 1-position Type 2-position Sequence Field 2-positions (01 - 99) assigned electronically
11.	Days in Inpatient Hospital	Computed from HCFA-1453 or HCFA-1450 discharge record.

Exhibit A

	Information	Description
12.	Type of Inpatient Dialysis	-Hemodialysis -Peritoneal -Both -CAPD -CCPD -Unspecified
13.	Number of Dialysis Sessions	
14.	Transplant Status	Source: HCFA-1483, HCFA-1453, HCFA-2745, HCFA-2746, HCFA-1450 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
15.	Inpatient Indicator	-HCFA-2745 only, no stay record or AMCS record received. -HCFA-2745 and stay record posted. -HCFA-2745, stay record and AMCS record posted. -No HCFA-2745, stay record and AMCS record only.
16.	Number of Pregnancies	
17	Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81); HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
18.	Ethnicity	-Hispanic Origin -Not of Hispanic Origin
19.	Date of Transplant	Date of reported transplant.
20.	Transplant Number	
21.	Date First Previous Failure	
22.	Date Second Previous Failure	

Information	Description
23. Date Third Previous Failure	
24. Provider Number	Provider identification number.
25. Surgeon's Name	
26. Recipient Blood Group	
Percent Reactive Antibody	
27. High	Expressed as a percentage.
28. At Transplant	Expressed as a percentage.
29. MLC (1-Way)	
30. MLC (2-Way)	
31. MLC (Not Done)	
32. Stim Index (1-Way)	
33. Stim Index (2-Way)	
34. Relative Response (1-Way)	
35. Relative Response (2-Way)	
36. HLA Haplotyped	
Recipient Haplotype Data	
37. Locus A1	
38. Locus A2	
39. Locus B1	
40. Locus B2	
41. Locus C1	
42. Locus C2	
43. Locus DR1	
44. Locus DR2	

Information	Description
45. Locus MB1	
46. Locus MB2	
47. Nephrectomy	-One -Two -No
48. Date of Nephrectomy	
49. Reason for Nephrectomy	Free fielded - Can contain up to 5 entries. -Uncontrolled hypertension -Infection -Reflux -Routine preparation for transplant -Other
50. Splenectomy	-Yes -No
51. Date of Splenectomy	
HBs AG Status	
52. Positive Ever	
53. Positive Now	
54. Antibody to HBs AG	
55. CMV Status: Antibody Present	-Yes -No -Unknown
Blood Transfusion Data	
56. Pre-Transplant	-Yes -No
57. Number of Transfusions	
58. Frozen Blood Used	
59. Date of Last Transfusion	
60. At Time of Transplant	-Yes -No

Information	Description
61. Creatinine Decline	-Yes -No -Unknown
62. Donor Type	-Cadaveric -Living related
63. Cadaveric Type	-Local -Shared
64. Living Related Type	-HLA Identical -Haplo Identical -Haplo Dissimilar -Identical Twin
Donor Data	
65. Sex Code	-Male -Female
66. Age at Transplant	Source: HCFA-2745, Item 22.
67. Blood Group	-O -A -B -AB
68. Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81) or HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
69. Ethnicity	-Hispanic Origin -Not of Hispanic origin
70. Infections at Harvest: HBs AG Positive	-Yes -No -Unknown
71. Infections at Harvest: CMV Antibody	-Yes -No -Unknown

Exhibit A

Information	Description
72. Infections at Harvest:	Other Infections-Positive sputum culture - gram negative bacteria -Positive urine culture greater than 10,000 per ml. -Positive urine culture greater than 1,000,000 per ml. -Pneumonia - gram positive -Pneumonia - gram negative -Meningitis -Bacteremia during admission -All others -No -Unknown
73. Cancer at Time of Harvest	-Intracranial -Extracranial -None -Both
74. Haplotype	-Yes -No
75. Locus A1	
76. Locus A2	
77. Locus B1	
78. Locus B2	
79. Locus C1	
80. Locus C2	
81. Locus DR1	
82. Locus DR2	
83. Locus MB1	
84. Locus MB2	
85. BUN	

Information	Description
86. Serum Creatinine	
87. Warm Ischemia Time (Minutes)	
88. Cold Time (Hours)	
89. Cold Time (Minutes)	
90. Pulsatile Perfusion (Hours)	
91. Pulsatile Perfusion (Minutes)	
Pretreatment	
92. Steroids	
93. Diuretics	
94. Diuretics (Mannitol)	
95. Diuretics (Lasix)	
96. Cyclophosphamide	
97. Methylprednisolone and cyclophosphamide	
98. Heparin	
99. Other	
100. Time Prior to Harvest	Time prior to harvest cyclophosphamide, methyprednisolone and cyclophosphamide or heparin given to the donor. -Given 0-5 hours prior -Given 5 or more hours prior

Exhibit A

ESRD Quarterly Dialysis Record

Information	Description
ESRD QUARTERLY DIALYSIS RECORD	Each dialysis record represents an aggregation by provider of all dialysis claims received during a quarter. There may be multiple dialysis records for any given quarter depending on the number of providers submitting claims. Source: HCFA-2743 (1/77 - 3/81), HCFA-1483 and HCFA-1450
1. Record Identification Code	Identifies the record format being processed.
2. Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3. Dialysis Information Post Date	Date most recent dialysis information was posted to PMMIS.
4. Dialysis Sequence Number	Two Digits (01-99). Ascending chronological sequence counter of dialysis records.
5. Year of Service	
6. Quarter of Service	Calendar quarter in which the service was rendered.
7. Dialysis Provider	Dialysis provider reporting medical evidence. Source: HCFA-2728, Item 18; HCFA-2742, Item 9.
Dialysis Session Data	
8. First Date of Service in Quarter	
9. Last Date of Service in Quarter	
10. Full Care in Unit	
11. Self-Care in Unit	

	Information	Description
12.	Self-Care Training	
13.	Home Care	
14.	Number of Input Records	Number of records merged to create quarterly record.
15.	Current Dialysis Type	Source: HCFA-2743, HCFA-1483 and HCFA-1450 Most current (date of service) reported type of dialysis. -Hemodialysis -Peritoneal -Both -CAPD -CCPD
16.	Units of Blood	Units of blood billed during quarter. Source: HCFA-1483 and HCFA-1450
17.	Filler	
18.	Source of Dialysis Information	-HCFA-2743 -HCFA-1483 -Both -HCFA-1450 -HCFA-1450 and HCFA-1483
19.	Dialysis Setting	-Full Care Unit -Self-Care Unit -Self-Care Training -Home
20.	Provider Certification Code	-Not Used -Dialysis Center -Hospital-based Facility -Non-Hospital Facility -Transplant/Dialysis Center -Inpatient Care Only -Not Certified

ESRD Inpatient Stay Record

	Information	Description
	ESRD PMMIS INPATIENT STAY RECORD	PMMIS does not include records for 1 day stays. Source: HCFA-1450, HCFA-1453
1.	Record Identification Code	Identifies the record format being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Inpatient Stay Record Post Date	Date the inpatient stay information was posted to the PMMIS.
4.	Stay Sequence Counter	Chronological sequence number of the stay.
5.	Provider Number	Identifier for the provider of service.
6.	Date of Admission	Julian date of admission to the provider.
7.	From Date	Julian date of first service.
8.	Through Date	Julian date for last service on bill submitted.
9.	Patient Status Code	-Discharge -Died -Still Patient -Visits Exhausted (HHA Only)
10.	Diagnosis Code	ICD-9-CM, left justified, blank filled.
11.	DRG (Diagnostic Related Group) Code	Code assigned from HCFA-1450 to indicate diagnosis group for payment purposes.
12.	DRG Discharge Destination	-To home, self-care. -To short term hospital. -To SNF -To ICF. -To other type facility. -To home health service care. -Left against medical advice.

Information	Description
13. DRG Outlier Code	-No outlier. -Day outlier. -Cost outlier. -Valid DRG received from intermediary. -HCFA developed DRG. -HCFA developed DRG using patient status code. -Non groupable.
14. Surgical Procedure Code	
15. Date of Surgery	Julian date of beneficiary's surgery.
16. Additional Surgery Indicator	Indicates the presence of additional surgery on the bill. -No surgery involved -No additional procedure -Yes, additional procedure -Unknown
17. Unibill Indicator	-HCFA-1450 format
18. Number of Dialysis Sessions	
19. Type of Inpatient Dialysis	-Hemodialyis -Peritoneal -Both -CAPD -CCPD -Unspecified
20. Transplant During This Stay	Source: HCFA-1450, HCFA-1453, HCFA-2745
21. Completeness of Stay Record	-Incomplete -Complete -Discharge
22. Type of Medical Coding	-ICDA-8 -ICD-9-CM
23. Kidney Acquisition Charge	Amount from inpatient bill.

Exhibit B

Facility Survey

Information	Description
Provider Data	
1. Provider Number	Facility identification number.
2. Provider Name	Name of facility.
3. Street Address	Street address of facility.
4. City	City of provider.
5. State	State abbreviation.
6. ZIP	5 position ZIP code.
7. CCPD	Code to indicate continuous cycling peritoneal dialysis.
8. Maintenance Hemo	Code to indicate staff-assisted hemodialysis at facility.
9. Maintenance Peri	Code to indicate staff-assisted peritoneal dialysis at facility.
10. Self-Care Hemo	Code to indicate in-unit self-care hemodialysis at facility.
11. Self-Care Peri	Code to indicate in-unit self-care peritoneal dialysis at facility.
12. Training Hemo	Hemo Code to indicate hemodialysis training at facility.
13. Training Peri	Code to indicate peritoneal dialysis training at facility.
14. CAPD Indicator	Indicates CAPD (continuous ambulatory peritoneal dialysis).
15. Total Stations	Total number of dialysis stations at facility. (Not always current.)
16. Certification Date	MMDDYY - Date of certification to provide renal services.

Information	Description
17. Certification Type	Code indicating type of facility certification. -Transplant Center -Dialysis Center -Dialysis Facility Hospital -Dialysis Facility -Transplant and Dialysis Center -Inpatient Care Only
18. Survey Cert	Certification type used for Facility Survey purposes.
19. Prior Cert Date	MMDDYY of prior certification.
20. Prior Cert Type	
21. Termination Date	MMDDYY of facility termination.
22. Termination Reason	Reason facility terminated, blank if no termination. -Involuntary withdrawal -Failure to meet health and safety standards -Failure to meet minimum utilization rates (MUR) -Failure to meet need requirement -Closed -Other
23. Prior Term Date	MMDDYY of prior termination.
24. Prior Term Reason	-Involuntary withdrawal -Failure to meet health and safety standards -Failure to meet minimum utilization rates (MUR) -Failure to meet need requirement -Closed -Other
25. Medicare Cert Date	MMDDYY of approval for reimbursement of Medicare services.
26. Intermediary	Identification number of current fiscal intermediary authorized to process bills from this provider.

Information	Description
27. ESRD Current Network	Renal network number of the provider.
28. Region	HCFA Regional Office Code.
29. Old Network	Network designation as published in Federal Register.
30. MSA	FIPS MSA number (4 positions) 5th Position = Size -1 million or more -250,000 to 1 million -100,000 to 250,000 -Less than 100,000 Note: Size not completed.
31. SSA County Code	Geographic code assigned by SSA standards.
32. FIPS	Geographic code assigned by FIPS standards (Federal Information Processing Standard Code).
33. Backup Provider	Backup dialysis provider - completed for free-standing facilities.
34. Cross Refer No.	For internal use only.
35. Convert No.	Indicates provider number for either change of ownership, transfer of stations, or number change
36. FY-end	MMDD of fiscal year end.
37. Telephone Number	Area code plus phone number of facility.

Information	Description
38. Type Ownership	Type of Ownership -Individual - For Profit -Partnership - For Profit -Corporation - For Profit -Other - For Profit -Individual - Not - For - Profit -Partnership - Not - For - Profit -Corporation - Not - For - Profit -Other - Not For Profit -State-Government Non-Federal -County-Government Non-Federal -City-Government Non-Federal -City/County-Government Non-Federal -Hospital District/Authority-Government Non-Federal -Other - Government Non-Federal -Veterans Administration - Government Federal -Public Health Service - Government Federal -Military - Government Federal -Other - Government Federal
39. Skeleton Record	For internal use only.
40. Change Date	MMYY of last information change in file.
Dialysis Patients	
41. Beginning In-Unit	In-unit patients receiving care at beginning of Survey period.
42. Beginning Home	Home patients receiving care at beginning of Survey period.
43. Beginning Total	Total patients receiving care at beginning of Survey period.
44. In-Unit First Start	In-unit started for first time ever - addition during Survey period.
45. Home First Start	Home started for first time ever - addition during Survey period.
46. In-Unit Restarted	In-unit restarted - addition during Survey period.

Information	Description
47. Home Restarted	Home restarted - addition during Survey period.
48. In-Unit Transferred	In-unit transferred from other dialysis unit - addition during Survey period.
49. Home Transferred In	Home transferred from other dialysis unit - addition during Survey period.
50. In-Unit Transplant Return	In-unit returned after transplantation - addition during Survey period.
51. Home Transplant Return	Home returned after transplantation - addition during Survey period.
52. In-Unit Deaths	In-unit deaths - losses during Survey period.
53. Home Deaths	Home deaths - losses during Survey period.
54. In-Unit Recovered	In-unit recovered kidney function -losses during Survey period.
55. Home Recovered	Home recovered kidney function - losses during Survey period.
56. In-Unit Received Transplant	In-unit received transplant - losses during Survey period.
57. Home Received Transplant	Home received transplant - losses during Survey period.
58. In-Unit Transferred Out	In-unit transferred to other dialysis unit - losses during Survey period.
59. Home Transferred Out	Home transferred to other dialysis unit - losses during Survey period.
60. In-Unit Discontinued	In-unit discontinued dialysis - losses during Survey period.
61. Home Discontinued	Home discontinued dialysis-losses during Survey period.
62. In-Unit Other	In-unit other (LTFU) - losses during Survey period.

Information	Description
63. Home Other	Home other (LTFU) - losses during Survey period.
64. Staff Hemo	Staff-assisted hemodialysis patients receiving care at end of Survey period.
65. Staff Peritoneal	Staff-assisted peritoneal dialysis patients receiving care at end of Survey period.
66. In-Unit Self Hemo	In-unit self-dialysis hemodialysis patients receiving care at end of Survey period.
67. In-Unit Self Peri	In-unit self-dialysis peritoneal dialysis patients receiving care at end of Survey period.
68. Hemo Training	Self-dialysis training hemodialysis patients receiving care at end of Survey period.
69. Peri Training	Self-dialysis training peritoneal dialysis patients receiving care at end of Survey period.
70. CAPD Self-dialysis	CAPD patients receiving care at end of Survey period.
71. CCPD	Self-dialysis CCPD patients receiving care at end of Survey period.
72. Total In-Unit	Total in-unit patients receiving care at end of Survey period.
73. Home Hemo	Hemodialysis home patients receiving care at end of Survey period.
74. Home Peri	Peritoneal dialysis home patients receiving care at end of Survey period.
75. Home CAPD	CAPD home patients receiving care at end of Survey period.
76. Home CCPD	CCPD home patients receiving care at end of Survey period.

Exhibit B

Information	Description
77. Total Home	Total home patients receiving care at end of Survey period.
78. Total Patients	Total patients receiving care at end of Survey period.
79. Medicare Enrolled	Currently enrolled in Medicare - patient eligibility status end of Survey period.
80. Application Pending	Medicare application pending - patient eligibility status end of Survey period.
81. Non-Medicare	Non-Medicare - patient eligibility status end of Survey period.
82. Home Hemo Completed Training	Home hemodialysis self-dialysis patients completing training.
83. In-Unit Hemo Completed Training	In-unit self hemodialysis - self-dialysis patients completing training.
84. Home Peri Completed Training	Home peritoneal dialysis - self-dialysis patients completing training.
85. In-Unit Peri Completed Training	In-unit self peritoneal dialysis - self-dialysis patients completing training.
86. CAPD Completed Training	CAPD self-dialysis patients completing training.
87. CCPD Completed Training	CCPD self-dialysis patients completing training.
88. Transient Patients Treated	Transient patients treated during Survey period.
Dialysis Treatments	
89. Transient Treatments	Number of transient patient treatments during Survey period.
90. Inpatient Hemo Treatments	Number of inpatient hemodialysis treatments.
91. Outpatient SA Hemo Treatments	Number of outpatient staff-assisted hemodialysis treatments.
92. Outpatients Self Hemo Treatments	Number of outpatient self-hemodialysis treatments.

Information	Description
93. Inpatient Peri Treatments	Number of inpatient peritoneal treatments.
94. Outpatient SA Peri Treatments	Number of outpatient staff-assisted peritoneal treatments.
95. Outpatient Self Peri Treatments	Number of outpatient self-peritoneal treatments.
96. Hemo Training Treatments	Number of hemodialysis training treatments.
97. Peri Training Treatments	Number of peritoneal dialysis training treatments.
98. CAPD Training Treatments	CAPD training treatments.
99. CCPD Training Treatments	CCPD training treatments.
Kidney Transplants	
100. Patients Transplanted	Patients who received transplant at this facility.
101. Medicare Patients Transplanted	Patients transplanted and currently enrolled in Medicare.
102. Medicare Application Pending	Patients transplanted and Medicare application pending.
103. Non-Medicare Transplants	Patients transplanted and non-Medicare.
104. Living Donor Transplant	Living donor transplants performed.
105. Cadaveric Donor Transplants	Cadaveric donor transplants performed.
106. Total Transplants	Total transplants performed.
107. Dialysis Awaiting Transplant	Dialysis patients awaiting transplant.
108. Non-Dialysis Awaiting Transplant	Non-dialysis patients awaiting transplant.
Disposition of Kidneys	
109. Harvested and Transplanted	Cadaver kidneys harvested and transplanted at this facility.

Information	Description
110. Harvested and Sent	Cadaver kidneys harvested at this facility and sent to another facility.
111. Harvested and Not Used	Cadaver kidneys harvested at this facility and not used.
112. Total Harvested	Total cadaver kidneys harvested at this facility.
113. Obtained and Transplanted	Cadaver kidneys obtained from another transplant hospital/OPA and transplanted at this facility.
114. Obtained and Sent	Cadaver kidneys obtained from another transplant hospital/OPA and sent to another facility.
115. Obtained and Not Used	Cadaver kidneys obtained from another transplant hospital/OPA and not used.
116. Total Obtained	Total cadaver kidneys obtained from another transplant hospital/OPA.
117. Obtained and Transplanted	Cadaver kidneys obtained from non-transplant hospital and transplanted at this facility.
118. Obtained and Sent	Cadaver kidneys obtained from non-transplant hospital and sent to another facility.
119. Obtained and Not Used	Cadaver kidneys obtained from non-transplant hospital and not used.
120. Total Obtained	Total cadaver kidneys obtained from non-transplant hospital.
121. Total Cadaver Transplanted	Total cadaver kidneys transplanted at this facility.
122. Total Cadaver Sent	Total cadaver kidneys sent to another facility.
123. Total Not Used	Total cadaver kidneys not used.
124. Survey Year	Year of Survey.

XI. Hospital Cost Report Information System (HCRIS)

Introduction

HCRIS is the national data base for Medicare hospital cost report data. The data base contains specific financial and statistical cost report data from Medicare certified hospitals and hospital/health care facility complexes beginning with hospital fiscal years ending on or after January 1, 1982. HCRIS also contains Title V and/or Title XIX data to the extent that the Medicare Fiscal Intermediaries (FI's) are responsible for processing and settling the hospitals' cost reports for these Federal programs. HCRIS data is kept on different files according to cost report version:

HCFA-2552-81 (Fiscal Year End (FYEs) on or after January 1, 1982, and before October 1, 1983.)

HCFA-2552-83 (TEFRA--Cost reporting periods beginning on or after October 1, 1982, and before October 1, 1983).

HCFA-2552-84 (PPS-1--Cost reporting periods beginning on or after October 1, 1983, and before October 1, 1984).

HCFA-2552-85 (PPS-II, III, IV, & V -- Cost reporting periods beginning on or after October 1, 1984 to the present).

Because the Medicare cost report allows for variable meaning lines, the HCRIS Master Files data is identified by combinations of four digit code rather than page, line and column. This provides for analysis of data by its meaning regardless of what report it was drawn from, but also requires cumbersome programming to use the data. To alleviate this problem for most data users, minimum data sets containing up to 550 fields per report have been created for PPS-I and beyond. These files use fixed field length structures (See Exhibit A, 2552-84 minimum data set record specifications. Similar data sets are also available for HCFA forms 2552-85, 2552-83, and 2552-81). The minimum data sets are available for use on the HCFA Data Center (HDC) system in both SAS and Sequential Format. For example, the PPS-I Sequential file name is:

PPS-I = MSØØ.@DAA2221.SEQ.PPS1.DATA(Ø)

For a SAS data set change the "SEQ" (Sequential) to "SAS".

For detail greater than that provided by the minimum data sets, the HCRIS staff will develop new or modify existing software to provide custom output as required by the data user.

Source Data--Hospital Cost Reports

The cost report is a variable document which must accommodate large teaching hospitals as well as small rural hospitals. The number of cost centers in each can vary from 15 to more than 300. Each cost report can comprise up to 3,600 data fields. More than 15,000 cost reports are processed through HCRIS annually, including initial submissions, resubmissions, and reopenings.

The HCRIS system maintains provider and tracking files that enable it to determine when a data extract is due from an FI as well as track the status of an extract from initial receipt onward. The HCRIS processing software begins with an FI generated file that was extracted from an electronically created cost report. This extract is created only after numerous math checks and edits have been applied by the FI's Automated Desk Review (ADR) software. The HCRIS software will reapply the edits and check for other inconsistencies that can occur during transmission. The final result on the HCRIS Master File is data that is much edited and perfected.

Footnotes

- Cost report data are occasionally received from FIs in hard copy form (300-400 per yr.) This is because the original report that is received from the provider is in non-standard form and therefore not able to be run on the FIs ADR program. In these instances the HCRIS staff will manually extract some of the more pertinent data for input to a master file.

- The HCFA 2552-81 system includes the identifying base period cost report used in the final PPS and/or TEFRA payment rate determination. It also includes data extracts for the HCFA 1007 (form for computing target amount for discharge under PPS and TEFRA.)

XII. Provider Specific File

Introduction

The Provider Specific File is developed by the intermediaries for use in the hospital prospective payment system pricing mechanism. A reimbursement price is computed for an individual inpatient hospital stay depending on the Diagnostic Related Group (DRG) the stay is classified in. The Provider Specific File is used in central office to support DRG recalibration; its completeness is measured by comparison to the POS file.

Each fiscal intermediary (FI) submits the file quarterly to central office via magnetic tape by duplicating the history of provider specific data elements from their PRICER software. In addition to completion checks, HCFA edits the records for its conformity to provider number ranges, data parameters, code range checks, and minimum/maximum dollar amounts. FI's are alerted if submissions are incomplete or in error and are required to resubmit a corrected version of the file. Exhibit A contains the record contents and description of the file.

Exhibit A

Information	Description
1. Provider Number	Alpha-numeric 6 character provider number.
2. Effective Date	Numeric YYMMDD. This date is the effective date of the provider's first PPS period or the first record for each provider. This date should be 1 day later than the end of the provider's original fiscal year. For subsequent records, for the same provider, this date is the effective date of the change.
3. Waiver Indicator	"N" means not waived (under PPS) and "Y" means waived (not under PPs).
4. Provider Type	This field indentifies providers that require special handling. Enter the appropriate code: 00 Short term facility (may also be left blank) 01 Sole commmunity provider 02 Longterm 03 Psychiatric 04 Rehabilitation facility 05 Pediatric 06 Hospital distinct parts 07 Rural referral center 08 Indian Health Service 09 Redesignated Rural - year 1 10 Redesignated Rural - year 2 11 Sole community/referral center provider 12 Alcohol facility
5. Current Census Division	Enter the appropriate code for the current census division: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific

Information	Description
6. Provider PPS Blend Period	Present when forcing provider into a specific PPS period, otherwise blank or 0-6. NOTE: Once a provider is forced into a specific PPS period, use an additional record each successive period through PPS period 5. If not, the provider stays in the PPS period of the last record indefinitely
7. Metropolitan Statistical Area (MSA)	Enter the appropriate code for the metropolitan statistical area or 9999 for rural.
8. Fiscal Year End	On the first record for each provider this is the fiscal year end of the provider's last year before PPS. (PPS bills will be accepted for dates after this date.) For subsequent provider records this only changes if the provider changes fiscal year end, e.g., a change of ownership.
9. Case Mix Adjusted	The PPS base year cost per discharge divided by the mix index. Zero for new providers.
10. Cost of Living Adjustment	The appropriate cost of living adjustment as listed below:

Area	FY84	FY 85 (10/1/84 4/30/86)	FY 86 (5/1/86 9/30/86)	FY 87 (10/1/86)
Alaska	1.250	1.250	1.250	1.250
Oahu	1.200	1.225	1.225	1.225
Kauai	1.175	1.150	1.150	1.175
Maui	1.200	1.200	1.200	1.200
Molakai	1.200	1.200	1.200	1.200
Lanai	1.200	1.200	1.200	1.200
Hawaii	1.100	1.125	1.125	1.150
All Other	1.000	1.000	1.000	1.000

Information	Description
11. Intern/Beds Ratio	The provider's intern/resident to bed ratio. Calculated by dividing the provider's full-time equivalent interns and residents by the number of available beds (as calculated in positions (50-54). Does not include interns and residents in anesthesiology who are employed to replace anesthetists or those assigned to excluded units. The count based upon the number of interns and residents assigned to the hospital on September 1. Zero for nonteaching hospitals.
12. Special Provider Update Factor (PRUP)	This field only for hospitals that have special update factors because their base period ended prior to September 30, 1982. For example, provider 010010 has a special update factor of 1.17268 effective 840203. If its current cost reporting period under PPS ends 12/31/84, the regular update factor would be 1.06003 and the new special update factor effective 850101 would be: 1.17268 * 1.06003 = 1.24308 Zero filled for non-PRUP hospitals.

NOTE: The effective date for PRUP changes computed this way is based upon cost reporting periods beginning on or after 10/1/84; i.e., a cost reporting period ending 9/30/84 has a PRUP effective 10/1/84; a cost reporting period ending 10/31/84 has its PRUP effective 11/01/84, etc.

13. Hospital Beds	Number of hospital beds. The number of adult and pediatric beds available for use by patients at the beginning of the cost reporting period. A bed means an adult bed, pediatric bed or newborn bed, maintained in a patient care area for patients in acute, long term or domiciliary areas of the hospital. Beds in labor rooms, birthing rooms, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences and other such areas which are regularly maintained and utilized for only a portion of the stay of patients, primarily for special procedures or not for inpatient lodging, are not termed "beds for this purpose."

Information	Description
14. Disproportionate Share Percentage (DSH)	Disproportionate share adjusted percentage. For discharges occurring on or after May 1, 1986 and before October 1, 1988, an additional payment for each PPS hospital that meets the criteria for serving a disproportionate share of low income patients. Place this factor in this field if the hospital qualifies for this additional payment. Edited to assure that the DSH adjustment factor does not exceed the following criteria: a. Urban hospital (location 18-21 is 0.40-9340) with 100 or more beds (location 50-54 is 100 or higher)- the DSH adjustment factor can not exceed .1500; the maximum under the law. b. Urban hospital with less than 100 beds- the adjustment factor is .0500. c. Rural hospital (location 18-21 is 9999)- the adjustment factor is .0400. Pricer multiplies this percentage (expressed as a decimal) by the Federal portion and outlier payment to determine the DSH adjustment. "Zero" for hospitals that do not qualify.
15. Cost to Charge Ratio	Derived from latest settled cost report and corresponding charge data from the billing file. This amount is computed by dividing the Medicare Operating Cost (from the cost report) by the Medicare Covered Charge (from the billing file).
16. Case Mix Index	This field is the case mix index that has been calculated and published by HCFA for each hospital (based on 1981 cost and billing data) reflecting the relative costliness of that hopital's mix of cases compared to a national average mix.
17. Date file corrected.	
18. Intermediary number.	
19. Fiscal Year Begin Date	Captured to identify providers with less than 365 day years.

Information	Description
20. Pass Thru Amount for Capital	Per diem amount derived from the cost report.
21. Pass Thru Amount For Direct Medical Education	Per diem amount derived from the cost report.
22. Pass Thru Amount	Per diem amount derived from the cost report.
23. Total Pass Thru Amount, Including Miscellaneous	Per diem amount derived from the cost report.
24. Supplemental Security Income Ratio	SSI ratio used to derive the disproportionate share adjustment.
25. Medicaid Ratio	Medicaid ratio used to derive the disproportionate share adjustment.

XIII. Medicare Automated Data Retrieval System (MADRS)

Introduction

OSDM has implemented a new research data base and retrieval system known as the Medicare Automated Data Retrieval System (MADRS). MADRS will facilitate obtaining person-based Medicare utilization data for specified Medicare beneficiaries or cohorts of beneficiaries; e.g., persons living in specified States and counties. It will no longer be necessary to search hundreds of magnetic tapes each year to obtain Medicare utilization data to satisfy research, demonstration and decision support projects requiring person-level data. There are approximately 340 million bills per year, 20 million Part A and 320 million Part B, for approximately 23 million Medicare beneficiaries using services.

For service years 1984 and afterwards, the most commonly requested billing data fields are stored on-line for the following types of bills:

- Inpatient Hospital
- Inpatient Skilled Nursing Facility
- Outpatient
- Home Health Agency
- Hospice
- Part B Payment Records for place of service "other than office"
- Summary data for Part B Payment Records with place of service "office" as follows:
  - Total reasonable charges for type of service "medical care"
  - Total amount reimbursed for type of service "medical care"
  - Total reasonable charges for type of service, "other than medical care"
  - Total amount reimbursed for type of service "other than medical care"

Additionally, for each person with Medicare utilization in the year there will be personal identifiers such as HI claim number, date of birth, sex, State, county, and ZIP Code of residence.

The MADRS file will be updated each month from bills that have been processed through the Health Insurance administrative operations. We intend to have on-line the current year's data plus three prior years. Earlier years will be written to tape and will be available for retrieval on a special request basis.

Retrieval of MADRS can be made using a finder record similar to that currently used for the administrative bill retrieval process. Currently, retrieval can be made for specific persons using their Health Insurance Claim Number and year of service or for persons living in specified States and/or counties. Future plans call for expansion to include other indices and linkage to an M204 data base.

Exhibits

A - MADRS Finder Records

B - Inpatient and SNF Data

C - Outpatient Data

D - HHA Data

E - Payment Record Data, Place of Service Office (Summarized Data)

F - Payment Record Data, Place of Service Other Than Office

G - Hospice Data

Medicare Automated Data Retrieval System Finder File

	Information	Description	Comments
1.	HI Claim Number	Beneficiary's Health Insurance Claim Number.	If only the first 9 positions of the claim number are specified, records for all beneficiaries housed under the account will be accessed.
2.	State Code	SSA geographic code.	Use only if HI Claim Number above NOT completed. 1/
3.	County Code	SSA geographic code.	Use only if HI Claim Number above NOT completed. If used, State Code must be completed. If entire State required, complete State Code, leave County Code blank. 1/
4.	Request Number	Control number assigned by the retrieval process.	
5.	Subrequest Number	Same as 4. above.	
6.	Date of Retrieval Run	Inserted during retrieval process.	
7.	Utilization Data Requested	Payment Records Inpatient Bills Outpatient Bills HHA Bills SNF Bills Hospice	For each data type, code 0 if "Not Requested." All other entries will default to "Requested."
8.	Year(s) of Data Requested	2 Position year for as many as 4 years.	System begins with 1984 data and houses current year and 3 prior years on-line.
9.	Record(s) Found for Request	Indication of Found/ Not Found inserted by retrieval process.	
10.	Requestor Use Area	For use at requestor's option. Does not affect retrieval process.	

1/ Selection will be made based on EITHER the beneficiaries' HI claim number or State/county of residence.

NOTE: As of 11/1/87, items 1, 2, and 3 described above have been implemented. The remaining items are intended as future enhancements.

Exhibit B

MADRS
INPATIENT AND SNF DATA

	Information	Description
1.	Record Identification Code	Part A bill.
2.	HI Claim Number	Beneficiary's Health Insurance Claim Number.
3.	State Code of Residence	SSA geographic code.
4.	County Code of Residence	SSA geographic code.
5.	ZIP Code of Residence	Standard code.
6.	Date of Birth	Year and Julian date of beneficiary's birth.
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Information	Description
12. Date of Service	Year and Julian date. Discharge date for final bills, through date for interim bills.
13. Debit/Credit indicator	Tabling value of record (+, -).
14. Reimbursement Amount	Amount paid by Medicare. Pass-through not included.
15. Total Charges	Total charges as reported by the provider.
16. Payment - Edit Code	- Covered I/P or SNF bill - Non-covered I/P or SNF bill
17. Transaction Code	-Christian Science SNF -Psychiatric Hospital Facility -Tuberculosis Hospital Facility -General Care Hospital Facility -Regular SNF
18. Query Code	Code indicating status of bill: -Interim Bill -Final Bill -Discharge Notice (Non-covered Bill) -Debit Adjustment -Credit Adjustment
19. Provider Number	Provider number shown on bill.
20. Distinct Part Code	-Psychiatric Unit -Rehabilitation Unit -Swing-Bed Hospital -Alcohol/Drug Unit
21. Diagnoses Codes	ICD-9-CM Coding - Maximum of 5 - Principal diagnosis is first.
22. Date of First Procedure	Year and Julian date of first procedure.
23. Procedure Codes	ICD-9-CM Volume 3 - Maximum of 3.

	Information	Description
24.	Date of Second Procedure	Year and Julian date of second procedure.
25.	Date of Third Procedure	Year and Julian date of third procedure
26.	Approval Date	Year and Julian date. claim approved
27.	PPS Indicator	-Covered by PPS -Not covered by PPS
28.	DRG	Diagnoses Related Group derived from diagnoses and procedures.
29.	Discharge Destination Code	-To Home, Self Care -To Short-Term Hospital -To SNF -To ICF -To Other Type Facility -To Home, Health Service Care -Left Against Medical Advise -Died -Still Patient
30.	Medical Record Number	Assigned by provider to patient records.
31.	Admission Date	Year and Julian date.
32.	From Date	Year and Julian date of start date of this bill.
33.	Length of Stay	-For final bills Number of days from admission to discharge. At least 1 is always assumed. -For interim bills -Coded 0
34.	Total Inpatient Days	Number of days from admission to "To Date" for all interim and final bills.
35.	Inpatient Covered Days	Number of covered days.

	Information	Description
*36.	Disproportionate Share Rate	Rate reflecting indigent population served. This factor is included in reimbursement amount.
*37.	Indirect Medical Education Amount	Reimbursable amount for teaching hospitals only. This is not part of the reimbursement amount.
*38.	Kidney Acquisition Charge	Actual cost to acquire a kidney. Not included in reimbursement amount.
*39.	Pass-Through Per Diem	Daily rate of provider's overhead apportioned to this bill. Not included in reimbursement amount.
40.	Coinsurance Amount	Total amount for coinsurance.
41.	Primary Payor Code	Code indicating who is primarily responsible for payment. -Working aged beneficiary/spouse with employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault or any liability insurance -Worker's Compensation including black lung -VA, PHS or other federal agency -Medicare is primary payor
42.	Primary Payor Amount	The amount of Medicare expenses paid by primary payor. Zero for Medicare only bills.
43.	Pass-Through Source Code-Bill	-Cost Report -No pass-through available -Bill

* PPS Hospitals only

Exhibit C

MADRS
Outpatient Data

	Information	Description
1.	Record Identification Code	Part B bill other than payment record.
2.	HI Claim Number	Beneficiary's Health Insurance Claim Number.
3.	State Code of Residence	SSA geographic code.
4.	County Code of Residence	SSA geographic code.
5.	Zip Code of Residence	Standard code.
6.	Date of Birth	Year and Julian date of beneficiary's birth.
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

	Information	Description
12.	Date of Service	Year and Julian date date of last service.
13.	Debit/Credit Indicator	Tabling value of record (+, -).
14.	Reimbursement Amount	Amount paid by Medicare.
15.	Total Charges	Total charges.
16.	Payment - Edit Code	Code that indicates this is an outpatient bill.
17.	Transaction Code	Code indicating type of facility: -Outpatient
18.	Query Code	Code indicating status of bill: -Interim Bill -Final Bill -Debit Adjustment -Credit Adjustment
19.	Provider Number	Provider number shown on bill.
20.	Diagnoses Codes	ICD-9-CM Coding - Maximum of 5.
21.	Date of First Procedure	Year and Julian date.
22.	Procedure Codes	HCPCS Coding beginning 7/87 Maximum of 3 Otherwise ICD-9-CM, Volume 3.
23.	Date of Second Procedure	Year and Julian date.
24.	Date of Third Procedure	Year and Julian date.

	Information	Description
25.	Approval Date	Date claim approved - Year and Julian date.
26.	HCPCS Codes	HCPCS Surgical Procedure 1/ Codes - Maximum of 3.
27.	Date of 1st HCPCS Procedure	Year and Julian date. 1/
28.	Date of 2nd HCPCS Procedure	Year and Julian date. 1/
29.	Date of 3rd HCPCS Procedure	Year and Julian date. 1/

1/ Available only for services after 7/1/87.

MADRS
HHA DATA

	Information	Description
1.	Record Identification Code	-Part A -Part B
2.	HI Claim Number	Beneficiary's Health Insurance Claim Number.
3.	State Code of Residence	SSA geographic code.
4.	County Code of Residence	SSA geographic code.
5.	Zip Code of Residence	Standard code.
6.	Date of Birth	Year and Julian date of beneficiary's birth.
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB amd Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Exhibit D

	Information	Description
12.	Date of Service	Year and Julian date date of last service.
13.	Debit/Credit Indicator	Tabling value of record (+, -).
14.	Reimbursement Amount	Amount paid by Medicare.
15.	Total Charges	Total charges.
16.	Payment-Edit Code	Code indicating this is an HHA bill.
17.	Transaction Code	Code indicating type of facility: -HHA
18.	Query Code	Code indicating status of bill: -Interim Bill -Visits Exhausted (HHA) -Final Bill -Debit Adjustment -Credit Adjustment
19.	Provider Number	Provider number of HHA bill.
20.	Diagnoses Codes	ICD-9-CM Code - Maximum of 5.
21.	Approval Date	Year and Julian date claim approved.
22.	Patient Status	-Died -Still Patient -Visits Exhausted
23.	Service From Date	Year and Julian beginning date of stay or service.
24.	Total HHA Visits	Home Health Agency visits.
25.	Total HHA Visit Charges	Total charges for HHA visits.

MADRS
Payment Record Data - Place of Service Office

NOTE: These records are summarized to a single record per beneficiary for each calendar year (repeated by type of service Medical and type of service Non-Medical).

	Information	Description
1.	Record Identification Code	Part B payment record.
2.	HI Claim Number	Beneficiary's Health Insurance Claim Number.
3.	State Code of Residence	SSA geographic code.
4.	County Code of Residence	SSA geographic code.
5.	Zip Code of Residence	Standard code.
6.	Date of Birth	Year and Julian date of beneficiary's birth.
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Original Reason For HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Reimbursement Amount	
11.	Total Allowed Charges	This field is the sum of medical charges plus psychiatric charges.
12.	Summary Indicator	This field contains a constant "SUMRY".

Exhibit E

	Information	Description
13.	Place of Service	Office
14.	Type of Service	-Medical Care -Other than Medical Care

NOTE: Place of service and type of service is determined by largest allowed charge reported on bill.

MADRS
Payment Record Data - Place of Service Other Than Office

	Information	Description
1.	Record Identification Code	Part B payment record.
2.	HI Claim Number	Beneficiary's Health Insurance Claim Number.
3.	State Code of Residence	SSA geographic code.
4.	County Code of Residence	SSA geographic code.
5.	Zip Code of Residence	Standard code.
6.	Date of Birth	Year and Julian date of beneficiary's birth.
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Exhibit F

	Information	Description
12.	Date of Service	Year and Julian date of date of last service.
13.	Debit - Credit Indicator	Tabling value of record (+, -).
14.	Reimbursement Amount	Amount paid by Medicare.
15.	Total Allowed Charges	This field is the sum of medical charges plus psychiatric charges.
16.	Entry Code	A code for type payment record being submitted: -Original debit -Supplemental -Full credit -Partial credit -Replacement debit -Partial debit -Correction record acknowledges full overpayment; also acknowledges an A reject previously submitted. Correction record acknowledges partial overpayment.
17.	Entry Re-Code	-Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records
18.	Carrier Number	Carrier number from payment record.

Information	Description
19. Place of Service	-Home -Inpatient Hospital -SNF/Nursing Home -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center
20. Type of Service	-Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Charges for whole blood or packed red blood cells -Purchase or rental of used DME -Surgical second opinion -Surgical third opinion blank for per diem records -Alternate payment method for maintenance dialysis -Live kidney donor
21. Specialty Code	Physician or supplier specialty code.
22. Date Paid	Year and Julian date.

NOTE: Place of Service and Type of Service is determined by largest allowed charge reported on bill.

MADRS
HOSPICE DATA

	Information	Description
1.	Record Identification Code	-Part A bill -Part B payment record -Part B bill other than payment record
2.	HI Claim Number	Beneficiary's Health Insurance Claim Number.
3.	State Code of Residence	SSA geographic code.
4.	County Code of Residence	SSA geographic code.
5.	Zip Code of Residence	Standard code.
6.	Date of Birth	Year and Julian date of beneficiary's birth.
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Information	Description
12. Date of Last Service	Year and Julian date of date of last service.
13. Debit/Credit Indicator	Tabling value of record (+, -).
14. Reimbursement Amount	Amount paid by Medicare.
15. Total Charges	Total charges.
16. Payment - Edit Code	Code indicating this is a hospice bill.
17. Transaction Code	Codes indicating type of facility: -Hospice
18. Query Code	Code indicating status of bill: -Interim Bill -Final Bill -Debit Adjustment -Credit Adjustment
19. Provider Number	Provider number of hospice.
20. Diagnosis Codes	ICD-9-CM Code- Maximum of 5.
21. Approval Date	Year and Julian date claim approved.
22. Hospice Discharge Destination	01 - To home, self care 02 - To Short Term Hospital 03 - To SNF 04 - To ICF 05 - To other type facility 06 - To home, Health Service care 07 - Left against medical advice 30 - Still patient 40 - Died at home 41 - Died in a medical institution 42 - Place of death unknown
23. Hospice Period Number	1, 2, or 3.

	Information	Description
24.	Service From Date	Year and Julian beginning date of stay or service.
25.	Hospice Start Date	Year and Julian date
26.	Inpatient Days of Care	Total Inpatient days of care.
27.	Length of Billing Period	Number of days from date of first service through date of last service. Must be at least 1.

APPENDIX A: GLOSSARY

Accommodation Charges - The routine hospital room and board charges (including charges for nursing services) for general care, coronary care and/or intensive care facilities.

Ancillary (Departmental) Charges - Those charges, other than routine room and board charges which are incidental to the hospital stay, including: operating room; anesthesia; outpatient services; blood administration; pharmacy; radiology; laboratory; medical, surgical and central supplies; physical therapy; occupational therapy; speech pathology; inhalation therapy; and "other".

Area of Residence - The county and State of the beneficiary based upon the mailing address used for cash benefits or the mailing address used for other purposes, e.g., premium billing. In some cases it may not be the actual area of beneficiary residence, e.g., if the beneficiary has a representative payee.

Assignment - Under Supplementary Medical Insurance (Part B), if the beneficiary and the provider (physician or supplier) both agree, the beneficiary may assign his rights to benefits to the provider. When this assignment method is used, the provider agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. The provider submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the 20 percent coinsurance and any deductible which remains unmet. The provider may then charge the beneficiary only for the coinsurance and any applicable deductible.

Benefit Period (Spell of Illness) - A period of time for measuring use of Hospital Insurance benefits. It begins on the entitled beneficiary's admission to a qualifying hospital or other facility and ends after the 60 consecutive days during which the individual was not an inpatient of any hospital or other facility primarily providing skilled nursing or rehabilitation services. Although there are limits to covered benefits per benefit period, there is no limit to the number of benefit periods a beneficiary can have. The beneficiary must pay the Hospital Insurance deductible for each new benefit period.

Beneficiary Identification Code (BIC) - A one or two position code that identifies the type of social security or railroad board benefits to which the beneficiary is entitled. The Social Security number of the primary beneficiary plus the BIC subscript represents the beneficiary's Health Insurance claim number.

Carrier - A private or public organization with which HCFA enters into agreement to help administer the Part B benefits under Medicare. Also referred to as "contractors," the carriers determine coverage and benefit amounts payable and make payment to physician/suppliers or beneficiaries.

Coinsurance - That portion of covered hospital and medical expenses, after subtraction of any deductible, for which the beneficiary is responsible. Under Hospital Insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal

to one-eighth of the inpatient hospital deductible. Under Supplemental Medical Insurance, after the annual deductible has been met, Medicare will generally pay 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the beneficiary.

Cross-Reference Number - A Health Insurance Claim Number related to the current number. In cases where an individual becomes entitled under a new number (for example, a woman formerly entitled under her husband's number becomes entitled under her own number), the actions under both are recorded under the current (new) number.

Deductible - The amount payable by the beneficiary for covered services before Medicare makes reimbursement. The Part A deductible is the initial amount in each benefit period which Medicare does not pay. The Part B deductible is the portion of reasonable charges (for covered services each calendar year) for which a beneficiary is responsible. These amounts, currently fixed by law, usually differ from year to year.

Diagnosis Related Groups (DRG's) - Each Diagnosis Related Group represents a broad clinical category based on body system involvement and disease etiology which are similar in use of resources. There are 473 categories. The following guidelines were used: (1) they must have been clinically consistent; (2) they must have had a sufficient number of patients; and (3) they must have covered the complete range of diagnoses represented in the ICD-9-CM, without overlap. They were developed by a Yale University research team and revised by Health Services International, Inc.

Disabled - For purposes of enrollment under Medicare, individuals under age 65 who have been entitled to disability benefits under the Social Security Act or the railroad retirement System for at least two years are considered to be disabled.

End-Stage Renal Disease (ESRD) - For purposes of enrollment under Medicare, individuals who have chronic kidney disease requiring renal dialysis or kidney transplant are considered to have end-stage renal disease. To qualify for Medicare coverage, the individual must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility; or if a person received a kidney transplant without starting or receiving dialysis.

Entitlement Date - The first day of the month in which an individual is entitled to Hospital Insurance (Part A) and/or Supplementary Medical Insurance (Part B) benefits.

General Enrollment Period (GEP) - An open season period between January 1 and March 31 each year for enrollment of individuals who missed initial enrollment, were terminated, or cancelled coverage voluntarily. (This procedure applies to Part B and voluntary Part A coverage for uninsured persons).

Group Practice Prepayment (GPPP) - An organization which has a formal arrangement with three or more full-time physicians to provide certain health services to the plan's members who, through the advance payment of premiums ordues, have contributed toward the cost of services.

Health Insurance Claim Number (HIC) - The individual identification number used in the Medicare program to identify each beneficiary. It consists of a Social Security or Railroad account number plus a Beneficiary Identification Code (BIC) that denotes the type of beneficiary for cash payment programs. Most HIC's are 9 digit numbers with letter suffixes and are issued by the Social Security Administration (SSA); those issued by the Railroad Retirement Board (RRB) can be either a 6 or 9 digit number with letter prefixes.

Health Insurance Master Record (HIM) - The HCFA master Medicare file of all individuals in current entitlement status as well as those who have ever been entitled to Hospital Insurance (Part A) and/or Supplemental Medical Insurance (Part B) benefits.

Health Maintenance Organization (HMO) - An organization which provides services to Medicare beneficiaries on a prepaid per capita basis. The HMO will provide both Part A and Part B services and can contract to operate as a "risk-basis" HMO (sharing in any savings it achieves) or a "cost-basis" HMO (with no provision for achieving savings or incurring losses).

Home Health Agency (HHA) - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home, such as: physical, occupational, or speech therapy; medical social services and home health aid services.

Hospital Insurance (HI) - HI (also known as Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for not less than 24 months to benefits under the social security or railroad retirement systems on the basis of disability, and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Interim Bill - A bill that does not cover a complete stay in a hospital or skilled nursing facility. It is used when the beneficiary is still receiving services, i.e., has not yet been discharged.

Intermediary - A private or public organization with which HCFA enters into agreement to help administer benefits to institutional providers under the Health Insurance program. The intermediaries determine costs for Part A benefits and make payment to providers.

Lifetime Reserve Days (LRD) - A beneficiary is entitled to 60 hospital lifetime reserve days for inpatient hospital care. At the time regular benefits are exhausted, the patient chooses whether or not to exercise the use of the reserve days. Medicare does not pay for the entire day; the beneficiary pays one half of the inpatient deductible. The beneficiary can use up to a maximum of 60 lifetime reserve days during their lifetime.

Master Beneficiary Record (MBR) - The basic social security master file of all retirement, survivor, disability and health insurance beneficiaries. It is the source

file for beneficiaries entitled to Medicare on the Health Insurance Master Record (HIM). HI beneficiary entitlement data, as well as termination, maintenance and premium billing and collection transactions, are processed and exchanged on an on-going basis between HCFA and SSA via the HI system and MBR interface.

Open Item - A record of admission to a hospital or skilled nursing facility for which a related discharge bill has not yet been received.

Outpatient Services - The medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Periodic Interim Payment (PIP) - A type of payment which furnishes providers with reimbursement for services more quickly than other arrangements. Intermediaries make payment bi-weekly, generally based on a per-inpatient-day rate calculated on estimated cost minus projected deductibles and coinsurance payable by the beneficiary for the services provided.

Premium - A monthly fee paid by Medicare beneficiaries. Part B beneficiaries pay a monthly premium which is updated every July to reflect any changes in program costs. Part A beneficiaries who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums.

Principal Diagnosis - The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Principal Surgical Procedure - The procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or that which was necessary to take care of a complication.

Professional Review Organization (PRO) - The non-profit physician review organization responsible for reviewing the medical necessity, appropriateness, and quality of health care services provided to Medicare beneficiaries by the provider of services. This is essentially the same function performed by Peer Review Organizations (PRO).

Provider of Service - An institution that furnishes Part A and or Part B health services to Medicare beneficiaries. All such institutions must meet the applicable eligibility requirements of Title XVIII of the Social Security Act and regulations issued thereunder. Hospitals, Skilled Nursing Facilities, Home Health Agencies and Independent Laboratories are examples of providers.

Query - The record sent by the intermediaries and carriers to HCFA Central Office to verify eligibility and coverage. Intermediaries, upon receipt of an initial hospital bill, must determine if the patient is an eligible Medicare beneficiary and if so, the amounts of related deductibles and coverage. This is accomplished by reporting the admission date to HCFA Central Office for screening against the

Health Insurance Master file. Information pertaining to entitlement, deductible status and coverage is returned to the appropriate intermediary. Carriers, upon receipt of a bill for medical services rendered, must also determine if the recipient of the services is an eligible Medicare beneficiary, and if so, the status of their deductibles. The carrier reports the medical services data to HCFA Central Office for screening against the Health Insurance Master file and receives, in return, information pertaining to entitlement and deductible status.

Railroad Retirement Board (RRB) Number - A distinctive number assigned by the RRB to identify the accounts of individuals entitled to benefits under its system. The RRB number may be either a six or a nine digit number, and when used as claim numbers, appears in conjunction with an applicable RRB Beneficiary Identification Code (BIC).

Reasonable Charge - An individual charge determination made by a carrier on a covered Part B medical service or supply. In the absence of unusual medical complications or circumstances it is the lowest of 1) the physician's or supplier's customary charge for that service; 2) the prevailing charge of the physician or supplier rendering the service.

Reasonable Cost - In processing claims for HI benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the health insurance program.

Reimbursement Amount - The amount reported as being paid by the Medicare program to or on behalf of the beneficiary for services provided by the physician or other provider of service including institutions. For institutional providers, this is usually an interim amount which is adjusted at the end of the provider's fiscal year based on its cost report. Beginning October 1983, for most hospitals, this amount will be based on the DRG.

Skilled Nursing Facility (SNF) - A specially qualified institution which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services and which meets specified regulatory certification requirements.

State Buy-In - Term given to the process by which a State may provide Supplementary Medical Insurance (SMI) coverage for its needy, eligible persons through an agreement with the Federal government under which the State pays their premiums.

Supplementary Medical Insurance (SMI) - SMI (also known as Part B) is a voluntary insurance program which provides insurance benefits for physician and other medical services in accordance with provisions of Title XVIII of the Social Security Act for aged and disabled individuals who elect to enroll under such program.

Value Code - A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

Professional Component included in charges and also billed separately to Carrier	For use on Medicare and Medicaid bills if the State requests this information.
Medicare Blood Deductible	Total cash blood deductible.
Medicare Cash Deductible	Medicare cash deductible.
Medicare Lifetime Reserve Amount in the First Calendar Year.	Medicare lifetime reserve amount charged the year of admission.
Medicare Coinsurance Amount in the First Calendar Year.	Medicare coinsurance amount charged in the year of admission.
Medicare Lifetime Reserve Amount in the Second Calendar Year.	Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
Medicare Coinsurance Amount in the Second Calendar Year	Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.
Working Aged Beneficiary/ Spouse with Employee Group Health Plan (EGHP)	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
ESRD Benficiary in the 12 Month Coordination Period with EGHP	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an ESRD beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Automobile, No Fault or any Liability Insurance	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.

Code Structure (con.)

Workmen's Compensation (WC), including Black Lung	Amount shown is that portion of a payment from a higher priority WC insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
VA, PHS, or other Government Program	Amount shown is that portion of a payment from a higher priority VA, PHS, or other Federal Agency made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
Patient Liability Amount	The amount shown is that which you or the PRO approved to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
Amount Approved by PRO to be paid under waiver	The amount shown has been determined by the PRO to be payable under waiver although all, or part of, the services on this bill have been denied.

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